

Calendar No. 562

103D CONGRESS
2D SESSION

S. 2374

A BILL

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

AUGUST 11, 1994

Read the second time and placed on the calendar

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IN THE SENATE OF THE UNITED STATES

AUGUST 9 (legislative day, AUGUST 8), 1994

Mr. DOLE (for himself and Mr. PACKWOOD) introduced the following bill;
which was read the first time

AUGUST 11, 1994

Read the second time and placed on the calendar

A BILL

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **TITLE I—AFFORDABLE HEALTH**
 2 **INSURANCE COVERAGE**
 3 **Subtitle A—Tax Incentives**

4 **SEC. 100. AMENDMENT OF 1986 CODE.**

5 Except as otherwise expressly provided, whenever in
 6 this subtitle an amendment or repeal is expressed in terms
 7 of an amendment to, or repeal of, a section or other provi-
 8 sion, the reference shall be considered to be made to a
 9 section or other provision of the Internal Revenue Code
 10 of 1986.

11 **PART I—EQUITABLE TAX TREATMENT OF**
 12 **INDIVIDUALS PROVIDING OWN HEALTH CARE**

13 **SEC. 101. DEDUCTION FOR INDIVIDUALS AND SELF-EM-**
 14 **PLOYED INDIVIDUALS PROVIDING OWN**
 15 **HEALTH INSURANCE.**

16 (a) GENERAL RULE.—Section 213 (relating to medi-
 17 cal, dental, etc. expenses) is amended by adding at the
 18 end the following new subsection:

19 “(f) HEALTH INSURANCE COSTS OF INDIVIDUALS.—

20 “(1) IN GENERAL.—The adjusted gross income
 21 limitation under subsection (a) shall not apply to
 22 amounts paid by an individual during the taxable
 23 year for qualified health insurance costs (and such
 24 amounts shall not be taken into account in deter-

1 mining whether such limitation applies to other
2 amounts).

3 “(2) QUALIFIED HEALTH INSURANCE COSTS.—
4 For purposes of this subsection—

5 “(A) IN GENERAL.—The term ‘qualified
6 health insurance costs’ means amounts paid for
7 insurance described in subsection (d)(1)(D)(i)
8 for the taxpayer, the taxpayer’s spouse, or any
9 dependent (as defined in section 152).

10 “(B) LIMITATIONS.—For purposes of sub-
11 paragraph (A)—

12 “(i) NO DEDUCTION FOR EMPLOYER-
13 SUBSIDIZED HEALTH COSTS.—Qualified
14 health insurance costs shall not include
15 any amount paid for insurance coverage of
16 an individual for any month if the individ-
17 ual is eligible to participate for such month
18 in an employer-subsidized health plan
19 maintained by any employer of the tax-
20 payer, the taxpayer’s spouse, or any de-
21 pendent.

22 “(ii) PHASE-IN.—In the case of tax-
23 able years beginning after 1993 and before
24 2000, only the following percentages of the

1 qualified health insurance costs shall be
 2 taken into account:

“If the taxable year begins in:	The applicable percentage is:
1994 or 1995	25 percent
1996 or 1997	50 percent
1998 or 1999	75 percent.

3 “(3) DEDUCTION NOT ALLOWED FOR SELF-EM-
 4 PLOYMENT TAX PURPOSES.—The deduction allow-
 5 able by reason of this subsection shall not be taken
 6 into account in determining an individual’s net earn-
 7 ings from self-employment (within the meaning of
 8 section 1402(a)) for purposes of chapter 2.”

9 (b) DEDUCTION ALLOWED AGAINST GROSS IN-
 10 COME.—Section 62(a) (defining adjusted gross income) is
 11 amended by inserting after paragraph (15) the following
 12 new paragraph:

13 “(16) DEDUCTION FOR HEALTH INSURANCE
 14 PREMIUMS.—The deduction allowed under section
 15 213(a) for amounts described in section 213(f).”

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply to taxable years beginning after
 18 December 31, 1993.

19 **PART II—MEDICAL SAVINGS ACCOUNTS**

20 **SEC. 111. DEDUCTION FOR CONTRIBUTIONS TO MEDICAL** 21 **SAVINGS ACCOUNTS.**

22 (a) IN GENERAL.—Part VII of subchapter B of chap-
 23 ter 1 (relating to additional itemized deductions for indi-

viduals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

“SEC. 220. CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

“(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction the amounts paid in cash during the taxable year by such individual to a medical savings account for the benefit of such individual or for the benefit of any spouse or dependent of such individual who is an eligible individual.

“(b) LIMITATIONS.—

“(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by the Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual’s spouse, or any dependent of such individual if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

“(2) DOLLAR LIMITATION.—

“(A) IN GENERAL.—The amount allowable as a deduction under subsection (a) with respect to any individual for the taxable year shall not exceed the lesser of—

1 “(i) \$2,000 (\$4,000 in the case of a
 2 medical savings account established on be-
 3 half of more than 1 individual), or

4 “(ii) the high deductible health plan
 5 differential.

6 In the case of a married individual filing a sep-
 7 arate return, clause (i) shall be applied by sub-
 8 stituting ‘\$1,000’ for ‘\$2,000’ and ‘\$2,000’ for
 9 ‘\$4,000’.

10 “(B) HIGH DEDUCTIBLE HEALTH PLAN
 11 DIFFERENTIAL.—For purposes of subparagraph
 12 (A)(ii), the high deductible health plan differen-
 13 tial with respect to any individual is the amount
 14 by which the cost of the high deductible health
 15 plan in which the individual is enrolled is less
 16 than the cost of the health plan providing the
 17 FedMed benefit package (within the meaning of
 18 section 21115(b) of the Social Security Act).

19 “(3) PHASE-IN OF DEDUCTION.—In the case of
 20 taxable years beginning after December 31, 1994,
 21 and before January 1, 2000, only the following per-
 22 centages of the deduction allowable under this sec-
 23 tion (without regard to this paragraph) shall be al-
 24 lowed:

**“If the taxable year
 begins in:**

1995 25 percent

**The applicable
 percentage is:**

**“If the taxable year
begins in:****The applicable
percentage is:**

1996 or 1997	50 percent
1998 or 1999	75 percent.

1 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
2 poses of this section—

3 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
4 individual’ means any individual—

5 “(A) who is covered under a high deduct-
6 ible health plan during any portion of the cal-
7 endar year with or within which the taxable
8 year begins, and

9 “(B) who is not eligible during such cal-
10 endar year—

11 “(i) to participate in an employer-sub-
12 sidized health plan maintained by an em-
13 ployer of the individual, the individual’s
14 spouse, or any dependent of either, or

15 “(ii) to receive any employer contribu-
16 tion to a medical savings account.

17 For purposes of subparagraph (B), a self-employed
18 individual (within the meaning of section 401(c))
19 shall not be treated as his own employer.

20 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The
21 term ‘high deductible health plan’ means a health
22 plan which has—

1 “(A) a deductible for each individual cov-
 2 ered by the plan which is not less than \$1,000,
 3 and

4 “(B) a family deductible which is not less
 5 than \$2,000.

6 “(3) MEDICAL SAVINGS ACCOUNT.—The term
 7 ‘medical savings account’ has the meaning given
 8 such term by section 7705.

9 “(4) TIME WHEN CONTRIBUTIONS DEEMED
 10 MADE.—A contribution shall be deemed to be made
 11 on the last day of the preceding taxable year if the
 12 contribution is made on account of such taxable year
 13 and is made not later than the time prescribed by
 14 law for filing the return for such taxable year (not
 15 including extensions thereof).”

16 (b) DEDUCTION ALLOWED AGAINST GROSS IN-
 17 COME.—Subsection (a) of section 62 (defining adjusted
 18 gross income), as amended by section 101, is amended by
 19 inserting after paragraph (16) the following new para-
 20 graph:

21 “(17) MEDICAL SAVINGS ACCOUNTS.—The de-
 22 duction allowed by section 220.”

23 (c) CLERICAL AMENDMENT.—The table of sections
 24 for part VII of subchapter B of chapter 1 is amended by
 25 striking the last item and inserting the following new item:

 “Sec. 220. Contributions to medical savings accounts.”

1 (d) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1994.

4 **SEC. 112. EXCLUSION FROM INCOME OF EMPLOYER CON-**
 5 **TRIBUTIONS TO MEDICAL SAVINGS AC-**
 6 **COUNTS.**

7 (a) IN GENERAL.—Section 106 (relating to contribu-
 8 tions by employers to accident and health plans) is amend-
 9 ed by adding at the end the following new subsection:

10 “(b) CONTRIBUTIONS TO MEDICAL SAVINGS AC-
 11 COUNTS.—

12 “(1) TREATMENT OF CONTRIBUTIONS.—

13 “(A) IN GENERAL.—Gross income of an
 14 employee who is covered by a high deductible
 15 health plan of an employer shall not include any
 16 employer contribution to a medical savings ac-
 17 count on behalf of the employee or the employ-
 18 ee’s spouse or dependents.

19 “(B) NO CONSTRUCTIVE RECEIPT.—No
 20 amount shall be included in the gross income of
 21 any employee solely because the employee may
 22 choose between the contributions described in
 23 subparagraph (A) and employer contributions
 24 to a health plan of the employer.

1 “(2) DOLLAR LIMITATION.—The amount which
2 may be excluded under paragraph (1) for any tax-
3 able year shall not exceed the lesser of—

4 “(A) \$2,000 (\$4,000 in the case of a medi-
5 cal savings account established on behalf of
6 more than one individual), or

7 “(B) the high deductible health plan dif-
8 ferential.

9 “(3) HIGH DEDUCTIBLE HEALTH PLAN DIF-
10 FERENTIAL.—For purposes of paragraph (2)(B), the
11 high deductible health plan differential with respect
12 to any employee is the amount by which the cost of
13 the high deductible health plan in which the em-
14 ployee is enrolled is less than—

15 “(A) the cost of the health plan (for the
16 same class of enrollment) which—

17 “(i) the employee is eligible to enroll
18 in through the employer, and

19 “(ii) has the highest cost of all health
20 plans in which the employee may enroll in
21 through the employer, or

22 “(B) if the employee is not eligible to en-
23 roll in any such health plan through the em-
24 ployer, the cost of the health plan providing the
25 FedMed benefit package.

1 “(4) DEFINITIONS.—For purposes of this sub-
2 section—

3 “(A) IN GENERAL.—The term ‘FedMed
4 benefit package’ has the meaning given such
5 term by section 21115(b) of the Social Security
6 Act.

7 “(B) HIGH DEDUCTIBLE HEALTH PLAN.—
8 The term ‘high deductible health plan’ has the
9 meaning given such term by section 220(c)(2).

10 “(C) MEDICAL SAVINGS ACCOUNT.—The
11 term ‘medical savings account’ has the meaning
12 given such term by section 7705.”

13 (b) EMPLOYER PAYMENTS EXCLUDED FROM EM-
14 PLOYMENT TAX BASE.—

15 (1) SOCIAL SECURITY TAXES.—

16 (A) Subsection (a) of section 3121 is
17 amended by striking “or” at the end of para-
18 graph (20), by striking the period at the end of
19 paragraph (21) and inserting “; or”, and by in-
20 serting after paragraph (21) the following new
21 paragraph:

22 “(22) any payment made to or for the benefit
23 of an employee if at the time of such payment it is
24 reasonable to believe that the employee will be able

1 to exclude such payment from income under section
2 106(b).”

3 (B) Subsection (a) of section 209 of the
4 Social Security Act is amended by striking “or”
5 at the end of paragraph (18), by striking the
6 period at the end of paragraph (19) and insert-
7 ing “; or”, and by inserting after paragraph
8 (19) the following new paragraph:

9 “(20) any payment made to or for the benefit
10 of an employee if at the time of such payment it is
11 reasonable to believe that the employee will be able
12 to exclude such payment from income under section
13 106(b) of the Internal Revenue Code of 1986.”

14 (2) RAILROAD RETIREMENT TAX.—Subsection
15 (e) of section 3231 is amended by adding at the end
16 the following new paragraph:

17 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-
18 TIONS.—The term ‘compensation’ shall not include
19 any payment made to or for the benefit of an em-
20 ployee if at the time of such payment it is reason-
21 able to believe that the employee will be able to ex-
22 clude such payment from income under section
23 106(b).”

24 (3) UNEMPLOYMENT TAX.—Subsection (b) of
25 section 3306 is amended by striking “or” at the end

1 of paragraph (15), by striking the period at the end
2 of paragraph (16) and inserting “; or”, and by in-
3 serting after paragraph (16) the following new para-
4 graph:

5 “(17) any payment made to or for the benefit
6 of an employee if at the time of such payment it is
7 reasonable to believe that the employee will be able
8 to exclude such payment from income under section
9 106(b).”

10 (4) WITHHOLDING TAX.—Subsection (a) of sec-
11 tion 3401 is amended by striking “or” at the end of
12 paragraph (19), by striking the period at the end of
13 paragraph (20) and inserting “; or”, and by insert-
14 ing after paragraph (20) the following new para-
15 graph:

16 “(21) any payment made to or for the benefit
17 of an employee if at the time of such payment it is
18 reasonable to believe that the employee will be able
19 to exclude such payment from income under section
20 106(b).”

21 (c) CONFORMING AMENDMENT.—Section 106 is
22 amended by striking “Gross” and inserting:

23 “(a) GENERAL RULE.—Gross”.

1 (d) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1994.

4 **SEC. 113. MEDICAL SAVINGS ACCOUNTS.**

5 (a) IN GENERAL.—Chapter 79 is amended by adding
 6 at the end the following new section:

7 **“SEC. 7705. MEDICAL SAVINGS ACCOUNTS.**

8 “(a) GENERAL RULE.—The term ‘medical savings
 9 account’ means a trust created or organized in the United
 10 States for the exclusive benefit of the beneficiaries of the
 11 trust, but only if the written governing instrument creat-
 12 ing the trust meets the following requirements:

13 “(1) Except in the case of a rollover contribu-
 14 tion described in subsection (c)(4), no contribution
 15 will be accepted unless—

16 “(A) it is in cash, and

17 “(B) it is made for a period during which
 18 the individual on whose behalf it is made is cov-
 19 ered under a high deductible health plan.

20 “(2) Contributions will not be accepted for any
 21 calendar year in excess of \$2,000 (\$4,000 in the
 22 case of an account established on behalf of the indi-
 23 vidual and the individual’s spouse and dependents).

24 “(3) The trustee is a bank (as defined in sec-
 25 tion 408(n)), insurance company (as defined in sec-

tion 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

“(4) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

“(5) No part of the trust assets will be invested in life insurance contracts.

“(6) The interest of an individual in the balance in the individual’s account is nonforfeitable.

“(b) TAX TREATMENT OF ACCOUNTS.—

“(1) ACCOUNT TAXED AS GRANTOR TRUST.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

“(B) TREATMENT OF CAPITAL LOSSES.—

With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall

1 be allowed only to the extent of capital gains
2 from such assets for such taxable year. Any
3 capital loss which is disallowed under the pre-
4 ceding sentence shall be treated as a capital
5 loss from the sale or exchange of such an asset
6 in the next taxable year.

7 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
8 GAGES IN PROHIBITED TRANSACTION.—

9 “(A) IN GENERAL.—If, during any taxable
10 year of the account beneficiary, such beneficiary
11 engages in any transaction prohibited by section
12 4975 with respect to the account, the account
13 shall cease to be a medical savings account as
14 of the first day of such taxable year.

15 “(B) ACCOUNT TREATED AS DISTRIBUTING
16 ALL ITS ASSETS.—In any case in which any ac-
17 count ceases to be a medical savings account by
18 reason of subparagraph (A) on the first day of
19 any taxable year, subsection (c) shall be applied
20 as if—

21 “(i) there were a distribution on such
22 first day in an amount equal to the fair
23 market value (on such first day) of all as-
24 sets in the account (on such first day), and

1 “(ii) no portion of such distribution
2 were used to pay qualified medical ex-
3 penses.

4 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
5 RITY.—If, during any taxable year, the account ben-
6 eficiary uses the account or any portion thereof as
7 security for a loan, the portion so used is treated as
8 distributed and not used to pay qualified medical ex-
9 penses.

10 “(c) TAX TREATMENT OF DISTRIBUTIONS.—

11 “(1) INCLUSION OF AMOUNTS NOT USED FOR
12 QUALIFIED MEDICAL EXPENSES.—

13 “(A) IN GENERAL.—Any amount paid or
14 distributed out of a medical savings account
15 which is not used exclusively to pay the quali-
16 fied medical expenses of the account beneficiary
17 or of the spouse or dependents of such bene-
18 ficiary shall be included in the gross income of
19 such beneficiary to the extent such amount does
20 not exceed the excess of—

21 “(i) the aggregate contributions to
22 such account which were not includible in
23 gross income by reason of section 106(b)
24 or which were deductible under section
25 220, over

1 “(ii) the aggregate prior payments or
2 distributions from such account which were
3 includible in gross income under this para-
4 graph.

5 “(B) SPECIAL RULES.—For purposes of
6 subparagraph (A)—

7 “(i) all payments and distributions
8 during any taxable year shall be treated as
9 1 distribution, and

10 “(ii) any distribution of property shall
11 be taken into account at its fair market
12 value on the date of the distribution.

13 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
14 FORE DUE DATE OF RETURN.—Paragraph (1) shall
15 not apply to the distribution of any contribution paid
16 during a taxable year to a medical savings account
17 to the extent that such contribution exceeds the
18 amount under subsection (a)(2) if—

19 “(A) such distribution is received by the
20 individual on or before the last day prescribed
21 by law (including extensions of time) for filing
22 such individual’s return for such taxable year,
23 and

1 “(B) such distribution is accompanied by
2 the amount of net income attributable to such
3 excess contribution.

4 Any net income described in subparagraph (B) shall
5 be included in the gross income of the individual for
6 the taxable year in which it is received.

7 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
8 FOR QUALIFIED MEDICAL EXPENSES.—

9 “(A) IN GENERAL.—The tax imposed by
10 chapter 1 on the account beneficiary for any
11 taxable year in which there is a payment or dis-
12 tribution from a medical savings account of
13 such beneficiary which is includible in gross in-
14 come under paragraph (1) shall be increased by
15 10 percent of the amount which is so includible.

16 “(B) EXCEPTION FOR DISABILITY OR
17 DEATH.—Subparagraph (A) shall not apply if
18 the payment or distribution is made after the
19 account beneficiary becomes disabled within the
20 meaning of section 72(m)(7) or dies.

21 “(C) EXCEPTION FOR DISTRIBUTIONS
22 AFTER AGE 59½.—Subparagraph (A) shall not
23 apply to any payment or distribution after the
24 date on which the account beneficiary attains
25 age 59½.

1 “(4) ROLLOVER CONTRIBUTION.—An amount is
2 described in this paragraph as a rollover contribu-
3 tion if it meets the requirements of subparagraphs
4 (A) and (B).

5 “(A) IN GENERAL.—Paragraph (1) shall
6 not apply to any amount paid or distributed
7 from a medical savings account to the account
8 beneficiary to the extent the amount received is
9 paid into a medical savings account for the ben-
10 efit of such beneficiary not later than the 60th
11 day after the day on which the beneficiary re-
12 ceives the payment or distribution.

13 “(B) LIMITATION.—This paragraph shall
14 not apply to any amount described in subpara-
15 graph (A) received by an individual from a
16 medical savings account if, at any time during
17 the 1-year period ending on the day of such re-
18 ceipt, such individual received any other amount
19 described in subparagraph (A) from a medical
20 savings account which was not includible in the
21 individual’s gross income because of the appli-
22 cation of this paragraph.

23 “(5) COORDINATION WITH MEDICAL EXPENSE
24 DEDUCTION.—For purposes of section 213, any pay-
25 ment or distribution out of a medical savings ac-

1 count for qualified medical expenses shall not be
2 treated as an expense paid for medical care to the
3 extent of the amount of such payment or distribu-
4 tion which is excludable from gross income solely by
5 reason of paragraph (1)(A).

6 “(6) TRANSFER OF ACCOUNT INCIDENT TO DI-
7 VORCE.—The transfer of an individual’s interest in
8 a medical savings account to an individual’s spouse
9 or former spouse under a divorce or separation in-
10 strument described in subparagraph (A) of section
11 71(b)(2) shall not be considered a taxable transfer
12 made by such individual notwithstanding any other
13 provision of this subtitle, and such interest at the
14 time of the transfer shall be treated as a medical
15 savings account of such spouse, and not of such in-
16 dividual. Any such account or annuity shall, for pur-
17 poses of this subtitle, be treated as maintained for
18 the benefit of the spouse to whom the interest was
19 transferred.

20 “(d) DEFINITIONS.—For purposes of this section—

21 “(1) QUALIFIED MEDICAL EXPENSES.—

22 “(A) IN GENERAL.—The term ‘qualified
23 medical expenses’ means any expense—

24 “(i) for medical care (as defined in
25 section 213(d)), or

1 “(ii) for qualified long-term care serv-
2 ices (as defined in section 213(g)).

3 “(B) EXCEPTION FOR INSURANCE.—

4 “(i) IN GENERAL.—Such term shall
5 not include any expense for insurance.

6 “(ii) EXCEPTIONS.—Clause (i) shall
7 not apply to any expense for—

8 “(I) coverage under a qualified
9 long-term care contract (as defined in
10 section 7702B(b)),

11 “(II) coverage under a health
12 plan during a period of continuation
13 coverage described in section
14 4980B(f)(2)(B),

15 “(III) coverage under a medicare
16 supplemental policy (as defined in sec-
17 tion 1882(g)(1) of the Social Security
18 Act), or

19 “(IV) payment of premiums
20 under part A or B of title XVIII of
21 the Social Security Act.

22 “(2) ACCOUNT BENEFICIARY.—The term ‘ac-
23 count beneficiary’ means the individual for whose
24 benefit the medical savings account is maintained.

1 “(e) CUSTODIAL ACCOUNTS.—For purposes of this
2 section, a custodial account shall be treated as a trust if—

3 “(1) the assets of such account are held by a
4 bank (as defined in section 408(n)), insurance com-
5 pany (as defined in section 816), or another person
6 who demonstrates to the satisfaction of the Sec-
7 retary that the manner in which such person will ad-
8 minister the account will be consistent with the re-
9 quirements of this section, and

10 “(2) the custodial account would, except for the
11 fact that it is not a trust, constitute a medical sav-
12 ings account described in subsection (a).

13 For purposes of this title, in the case of a custodial ac-
14 count treated as a trust by reason of the preceding sen-
15 tence, the custodian of such account shall be treated as
16 the trustee thereof.

17 “(f) REPORTS.—The trustee of a medical savings ac-
18 count shall make such reports regarding such account to
19 the Secretary and to the individual for whose benefit the
20 account is maintained with respect to contributions, dis-
21 tributions, and such other matters as the Secretary may
22 require under regulations. The reports required by this
23 subsection shall be filed at such time and in such manner
24 and furnished to such individuals at such time and in such
25 manner as may be required by those regulations.”

1 (b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
 2 (relating to tax on excess contributions to individual re-
 3 tirement accounts, certain section 403(b) contracts, and
 4 certain individual retirement annuities) is amended—

5 (1) by inserting “**MEDICAL SAVINGS AC-**
 6 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
 7 such section,

8 (2) by striking “or” at the end of paragraph
 9 (1) of subsection (a),

10 (3) by redesignating paragraph (2) of sub-
 11 section (a) as paragraph (3) and by inserting after
 12 paragraph (1) the following:

13 “(2) a medical savings account (within the
 14 meaning of section 7705(a)), or”, and

15 (4) by adding at the end the following new sub-
 16 section:

17 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
 18 ACCOUNTS.—For purposes of this section, in the case of
 19 a medical savings account (within the meaning of section
 20 7705(a)), the term ‘excess contributions’ means the
 21 amount by which the amount contributed for the taxable
 22 year to the account exceeds the amount which may be con-
 23 tributed to the account under section 7705(a)(2) for such
 24 taxable year. For purposes of this subsection, any con-
 25 tribution which is distributed out of the medical savings

1 account in a distribution to which section 7705(c)(2) ap-
2 plies shall be treated as an amount not contributed.”

3 (c) TAX ON PROHIBITED TRANSACTIONS.—Section
4 4975 (relating to prohibited transactions) is amended—

5 (1) by adding at the end of subsection (c) the
6 following new paragraph:

7 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
8 COUNTS.—An individual for whose benefit a medical
9 savings account (within the meaning of section
10 7705(a)) is established shall be exempt from the tax
11 imposed by this section with respect to any trans-
12 action concerning such account (which would other-
13 wise be taxable under this section) if, with respect
14 to such transaction, the account ceases to be a medi-
15 cal savings account by reason of the application of
16 section 7705(b)(2)(A) to such account.”, and

17 (2) by inserting “or a medical savings account
18 described in section 7705(a)” in subsection (e)(1)
19 after “described in section 408(a)”.

20 (d) FAILURE TO PROVIDE REPORTS ON MEDICAL
21 SAVINGS ACCOUNTS.—Section 6693 (relating to failure to
22 provide reports on individual retirement accounts or annu-
23 ities) is amended—

1 (1) by inserting “**OR ON MEDICAL SAVINGS**
 2 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
 3 such section, and

4 (2) by adding at the end of subsection (a) the
 5 following: “The person required by section 7705(f)
 6 to file a report regarding a medical savings account
 7 at the time and in the manner required by such sec-
 8 tion shall pay a penalty of \$50 for each failure un-
 9 less it is shown that such failure is due to reasonable
 10 cause.”

11 (e) CLERICAL AMENDMENTS.—

12 (1) The table of sections for chapter 43 is
 13 amended by striking the item relating to section
 14 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement
 accounts, medical savings accounts, certain 403(b)
 contracts, and certain individual retirement annu-
 ities.”

15 (2) The table of sections for subchapter B of
 16 chapter 68 is amended by inserting “or on medical
 17 savings accounts” after “annuities” in the item re-
 18 lating to section 6693.

19 **Subtitle B—Premium Assistance**

20 **SEC. 121. PREMIUM ASSISTANCE.**

21 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
 22 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
 23 as amended by section 201(a), is amended—

1 (1) by striking “and” at the end of paragraph
2 (62);

3 (2) by striking the period at the end of para-
4 graph (63) and inserting “; and”; and

5 (3) by adding at the end the following new
6 paragraph:

7 “(64) provide for a State program furnishing
8 premium assistance in accordance with part B.”.

9 (b) STATE PROGRAMS FOR PREMIUM ASSISTANCE.—
10 Title XIX of the Social Security Act (42 U.S.C. 1396 et
11 seq.) is amended by adding at the end the following new
12 part:

13 **“PART B—STATE PROGRAMS FOR PREMIUM**
14 **ASSISTANCE**

15 **“Subpart 1—Establishment of Premium Assistance**
16 **Programs**

17 **“SEC. 1951. REQUIREMENT TO OPERATE STATE PROGRAM.**

18 “(a) IN GENERAL.—A State with a State plan ap-
19 proved under part A shall have in effect a program for
20 furnishing premium assistance under section 1952 to fam-
21 ilies with incomes below certain income thresholds in cal-
22 endar years beginning after 1996.

23 “(b) DESIGNATION OF STATE AGENCY.—A State
24 may designate any appropriate State agency to administer
25 the program under this part.

1 **“SEC. 1952. ASSISTANCE WITH CERTIFIED HEALTH PLAN**
2 **PREMIUMS.**

3 “(a) ELIGIBILITY.—

4 “(1) IN GENERAL.—A family (as defined in sec-
5 tion 1957(4)) which has been determined by a State
6 under section 1953 to be a premium subsidy eligible
7 family (as defined in paragraph (2)) shall be entitled
8 to premium assistance in the amount determined
9 under subsection (b).

10 “(2) PREMIUM SUBSIDY ELIGIBLE FAMILY.—

11 “(A) IN GENERAL.—For purposes of this
12 part, the term ‘premium subsidy eligible family’
13 means a family which has a family income de-
14 termined under section 1957(2) which does not
15 exceed 150 percent of the poverty line (as de-
16 fined in section 1957(5)).

17 “(B) REDUCTION IN ELIGIBILITY PER-
18 CENTAGE.—For requirement that the President
19 reduce the percentage of the poverty line appli-
20 cable to family income under subparagraph (A),
21 see subpart 2.

22 “(b) AMOUNT OF ASSISTANCE.—

23 “(1) IN GENERAL.—Except as provided in para-
24 graph (4), the amount of premium assistance for a
25 month for a premium subsidy eligible family is the
26 lesser of—

1 “(A) the subsidy percentage specified in
2 paragraph (3) multiplied by $\frac{1}{12}$ th of the annual
3 premium for coverage under the certified health
4 plan in which the family is enrolled, or

5 “(B) the subsidy percentage specified in
6 paragraph (3) multiplied by $\frac{1}{12}$ th of the maxi-
7 mum subsidy amount for the year for the fam-
8 ily (determined under paragraph (2)).

9 “(2) MAXIMUM SUBSIDY AMOUNT.—

10 “(A) IN GENERAL.—The maximum subsidy
11 amount determined under this paragraph for a
12 year for a family is the maximum subscription
13 charge for the family’s class of enrollment
14 under all health benefits plans offered under
15 chapter 89 of title 5, United States Code for
16 the year, as adjusted under subparagraph (B).

17 “(B) ADJUSTMENTS.—The Secretary shall
18 adjust the maximum subscription charge for a
19 family determined under subparagraph (A) by
20 the age adjustment factors specified under sec-
21 tion 21114(b)(2)(C) and for geographic dif-
22 ferences in health care costs based on the com-
23 munity rating area in which the family resides.

24 “(3) SUBSIDY PERCENTAGE.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), the term ‘subsidy percent-
3 age’ means—

4 “(i) 100 percent if the family income
5 does not exceed 100 percent of the poverty
6 line;

7 “(ii) 90 percent if the family income
8 exceeds 100 percent of the poverty line but
9 does not exceed 110 percent of the poverty
10 line;

11 “(iii) 80 percent if the family income
12 exceeds 110 percent of the poverty line but
13 does not exceed 115 percent of the poverty
14 line;

15 “(iv) 70 percent if the family income
16 exceeds 115 percent of the poverty line but
17 does not exceed 125 percent of the poverty
18 line;

19 “(v) 60 percent if the family income
20 exceeds 120 percent of the poverty line but
21 does not exceed 125 percent of the poverty
22 line;

23 “(vi) 50 percent if the family income
24 exceeds 125 percent of the poverty line but

1 does not exceed 130 percent of the poverty
2 line;

3 “(vii) 40 percent if the family income
4 exceeds 130 percent of the poverty line but
5 does not exceed 135 percent of the poverty
6 line;

7 “(viii) 30 percent if the family income
8 exceeds 135 percent of the poverty line but
9 does not exceed 140 percent of the poverty
10 line;

11 “(ix) 20 percent if the family income
12 exceeds 140 percent of the poverty line but
13 does not exceed 145 percent of the poverty
14 line; and

15 “(x) 10 percent if the family income
16 exceeds 145 percent of the poverty line but
17 does not exceed 150 percent of the poverty
18 line.

19 “(B) SPECIAL RULES.—

20 “(i) AFDC RECIPIENTS.—For a family
21 receiving aid to families with dependent
22 children under part A or E of title IV, the
23 subsidy percentage shall be 100 percent.

24 “(ii) NON-CASH MEDICAID ELIGI-
25 BLES.—For a family that would have been

1 eligible for medical assistance under the
2 State plan under part A under the eligi-
3 bility rules in effect in the year preceding
4 the first year the State began integrating
5 individuals into the premium assistance
6 program under this part in accordance
7 with section 1932(a), the subsidy percent-
8 age shall be 100 percent.

9 “(C) REDUCTION IN SUBSIDY PERCENT-
10 AGE.—For requirement that the President re-
11 duce the subsidy percentages under subpara-
12 graph (A), see subpart 2.

13 “(c) PAYMENTS.—

14 “(1) IN GENERAL.—The amount of the pre-
15 mium assistance available to a premium subsidy eli-
16 gible family under subsection (b) shall be paid by
17 the State directly to the certified health plan in
18 which the family is enrolled. Payments under the
19 preceding sentence shall commence in the first
20 month during which the family is enrolled in a cer-
21 tified health plan and determined under section
22 1953 to be a premium subsidy eligible family.

23 “(2) ADMINISTRATIVE ERRORS.—A State is fi-
24 nancially responsible for premium assistance paid
25 based on an eligibility determination error to the ex-

1 tent the State’s error rate for eligibility determina-
2 tions exceeds a maximum permissible error rate to
3 be specified by the Secretary.

4 **“SEC. 1953. ELIGIBILITY DETERMINATIONS.**

5 “(a) IN GENERAL.—The Secretary shall promulgate
6 regulations specifying requirements for State programs
7 under this part with respect to determining eligibility for
8 premium assistance, including requirements with respect
9 to—

10 “(1) application procedures;

11 “(2) information verification procedures;

12 “(3) timeliness of eligibility determinations;

13 “(4) procedures for applicants to appeal adverse
14 decisions; and

15 “(5) any other matters determined appropriate
16 by the Secretary.

17 “(b) SPECIFICATIONS FOR REGULATIONS.—The reg-
18 ulations promulgated by the Secretary under subsection
19 (a) shall include the following requirements:

20 “(1) APPLICATIONS.—A State program shall
21 provide that a family may file an application for as-
22 sistance with an agency designated by the State at
23 any time, in person or by mail.

1 “(2) APPLICATION FORM.—A State program
2 shall provide for the use of an application form de-
3 veloped by the Secretary under subsection (c).

4 “(3) DISTRIBUTION OF APPLICATIONS.—A
5 State program shall make available applications for
6 assistance through employers and appropriate public
7 agencies or organizations.

8 “(4) DISTRIBUTION OF INFORMATION ON CER-
9 TIFIED HEALTH PLANS.—A State program shall pro-
10 vide that each family applying for assistance under
11 this part receives the information determined appro-
12 priate by the Secretary on each certified health plan
13 providing the FedMed benefits package as described
14 in section 21115(b) offered in the community rating
15 area in which the family resides.

16 “(5) REQUIREMENT TO SUBMIT REVISED AP-
17 PLICATION.—A State program shall, in accordance
18 with regulations promulgated by the Secretary, re-
19 quire families to submit revised applications during
20 a year to reflect increases in estimated family in-
21 comes during the year. The State shall revise the
22 amount of any premium assistance based on such a
23 revised application.

24 “(6) AFDC APPLICANTS.—A State program
25 shall include a procedure under which families ap-

1 plying for benefits under title IV shall have an op-
2 portunity to apply for assistance under this part in
3 connection with such application.

4 “(7) VERIFICATION.—A State program shall
5 provide for verification of the information supplied
6 in applications under this part.

7 “(c) ADMINISTRATION OF STATE PROGRAMS.—

8 “(1) IN GENERAL.—The Secretary shall estab-
9 lish standards for States operating programs under
10 this part which ensure that such programs are oper-
11 ated in a uniform manner with respect to application
12 procedures, data processing systems, and such other
13 administrative activities as the Secretary determines
14 to be necessary.

15 “(2) APPLICATION FORMS.—The Secretary
16 shall develop a standard application form for assist-
17 ance which shall—

18 “(A) be simple in form and understandable
19 to the average individual;

20 “(B) require the provision of information
21 necessary to make a determination as to wheth-
22 er a family is a premium subsidy eligible family
23 including a declaration of estimated income by
24 the family based, at the election of the family—

1 “(i) on multiplying by a factor of 4
 2 the family’s family income for the 3-month
 3 period immediately preceding the month in
 4 which the application is made, or

5 “(ii) on estimated income for the en-
 6 tire year for which the application is sub-
 7 mitted; and

8 “(C) require attachment of such docu-
 9 mentation as deemed necessary by the Sec-
 10 retary in order to ensure eligibility for assist-
 11 ance.

12 “(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM
 13 SUBSIDIES.—A determination by a State that a family is
 14 a premium subsidy eligible family shall be effective for the
 15 calendar year for which such determination is made unless
 16 a revised application submitted under subsection (b)(5) in-
 17 dicates that a family is no longer eligible for premium as-
 18 sistance.

19 **“SEC. 1954. END-OF-YEAR RECONCILIATION FOR PREMIUM**
 20 **ASSISTANCE.**

21 “(a) IN GENERAL.—

22 “(1) REQUIREMENT TO FILE STATEMENT.—A
 23 family which received premium assistance under this
 24 part from a State for any month in a calendar year
 25 shall file with the State an income reconciliation

1 statement to verify the family's family income for
 2 the year. Such a statement shall be filed at such
 3 time, and contain such information, as the State
 4 may specify in accordance with regulations promul-
 5 gated by the Secretary.

6 “(2) NOTICE OF REQUIREMENT.—A State shall
 7 provide a written notice of the requirement under
 8 paragraph (1) at the time a family submits an appli-
 9 cation for premium assistance under this part and at
 10 the end of the year to a family which received such
 11 assistance from such State in any month during the
 12 year.

13 “(b) RECONCILIATION OF PREMIUM ASSISTANCE
 14 BASED ON ACTUAL INCOME.—

15 “(1) IN GENERAL.—Based on and using the in-
 16 come reported in the reconciliation statement filed
 17 under subsection (a) with respect to a family, the
 18 State shall compute the amount of premium assist-
 19 ance that should have been provided under this part
 20 with respect to the family for the year involved.

21 “(2) OVERPAYMENT OF ASSISTANCE.—If the
 22 total amount of the premium assistance provided
 23 was greater than the amount computed under para-
 24 graph (1), the family is liable to the State to pay an
 25 amount equal to the amount of the excess payment.

1 Any amount collected by a State under this para-
2 graph shall be submitted to the Secretary in a timely
3 manner.

4 “(3) STATE OPTION.—A State may, in accord-
5 ance with regulations promulgated by the Secretary,
6 establish a procedure under which any overpayments
7 of premium assistance determined under paragraph
8 (2) with respect to a family for a year may be col-
9 lected or paid, as appropriate, through adjustments
10 to the premium assistance furnished to such family
11 in the succeeding year.

12 “(c) VERIFICATION.—Each State may use such infor-
13 mation as it has available to verify income of families with
14 applications filed under this part.

15 “(d) PENALTIES FOR FAILURE TO FILE.—In the
16 case of a family which is required to file a statement under
17 this section in a year who fails to file such a statement
18 by such date as the Secretary shall specify in regulations,
19 the entire amount of the premium assistance provided in
20 such year shall be considered an excess amount under sub-
21 section (b)(2) and such family shall not be eligible for pre-
22 mium assistance under this part until such statement is
23 filed. A State, using rules established by the Secretary,
24 shall waive the application of this subsection if the family
25 establishes, to the satisfaction of the State under such

1 rules, good cause for the failure to file the statement on
2 a timely basis.

3 **“SEC. 1955. PENALTIES FOR MATERIAL MISREPRESENTA-**
4 **TION AND FALSE INFORMATION.**

5 “(a) IN GENERAL.—Any individual who knowingly
6 makes a material misrepresentation of information or pro-
7 vides false information in an application for assistance
8 under this part under section 1953 or an income reconcili-
9 ation statement under section 1954 shall be liable to the
10 Federal Government for the amount any premium assist-
11 ance received by the individual on the basis of such mis-
12 representation or false information and interest on such
13 amount at a rate specified by the Secretary, and shall,
14 in addition, be liable to the Federal Government for
15 \$2,000 or, if greater, 3 times the amount of any premium
16 assistance received by the individual on the basis of such
17 misrepresentation or false information.

18 “(b) COLLECTION OF PENALTY AMOUNTS.—A State
19 which receives an application for assistance or an income
20 reconciliation statement with respect to which a material
21 misrepresentation has been made or false information has
22 been provided shall collect the penalty amount required
23 under subsection (a) and submit 50 percent of such
24 amount to the Secretary in a timely manner.

1 **“SEC. 1956. PAYMENTS TO STATES.**

2 “(a) IN GENERAL.—

3 “(1) PAYMENTS FOR PREMIUM ASSISTANCE.—A
4 State operating a program for furnishing premium
5 assistance under this part shall be entitled to receive
6 payments in an amount equal to the amount of pre-
7 mium assistance paid on behalf of premium subsidy
8 eligible families. Such payments shall be made at
9 such time and in such form as provided in regula-
10 tions promulgated by the Secretary.

11 “(2) MATCHING PAYMENTS FOR ADMINISTRA-
12 TIVE EXPENSES.—The Secretary shall pay to each
13 State operating a program for furnishing premium
14 assistance under this part, for each quarter begin-
15 ning with the quarter commencing January 1, 1997,
16 an amount equal to 50 percent of the total amount
17 expended by the State during the quarter as found
18 necessary by the Secretary for the proper and effi-
19 cient administration of the program.

20 “(3) STATE ENTITLEMENT.—This subsection
21 constitutes budget authority in advance of appro-
22 priations Acts, and represents the obligation of the
23 Federal Government to provide payments to States
24 operating programs under this part in accordance
25 with this subsection.

1 “(b) FUNDING.—The amount paid to States under
 2 subsection (a) shall be paid by the Secretary from out of
 3 any funds in the Treasury of the United States not other-
 4 wise appropriated.

5 “(c) AUDITS.—The Secretary shall conduct regular
 6 audits of the activities under the State programs con-
 7 ducted under this part.

8 **“SEC. 1957. DEFINITIONS AND DETERMINATIONS OF IN-**
 9 **COME.**

10 “For purposes of this part:

11 “(1) CERTIFIED HEALTH PLAN.—The term
 12 ‘certified health plan’ means a certified health plan
 13 (within the meaning of section 21003(b)) providing
 14 the FedMed benefits package as described in section
 15 21115(b).

16 “(2) DETERMINATIONS OF INCOME.—

17 “(A) IN GENERAL.—The term ‘income’
 18 means adjusted gross income (as defined in sec-
 19 tion 62(a) of the Internal Revenue Code of
 20 1986)—

21 “(i) determined without regard to sec-
 22 tions 135, 162(l), 911, 931, and 933 of
 23 such Code; and

24 “(ii) increased by—

1 “(I) the amount of interest re-
2 ceived or accrued which is exempt
3 from tax, plus

4 “(II) the amount of social secu-
5 rity benefits (described in section
6 86(d) of such Code) which is not in-
7 cludible in gross income under section
8 86 of such Code.

9 “(B) FAMILY INCOME.—The term ‘family
10 income’ means, with respect to a family, the
11 sum of the income for all members of the fam-
12 ily, not including the income of a dependent
13 child with respect to which no return is re-
14 quired under the Internal Revenue Code of
15 1986.

16 “(3) ELIGIBLE INDIVIDUAL.—

17 “(A) IN GENERAL.—The term ‘eligible in-
18 dividual’ means an individual who is residing in
19 the United States and who is—

20 “(i) a citizen or national of the United
21 States; or

22 “(ii) a lawful alien (as defined in sub-
23 paragraph (C)).

24 “(B) EXCLUSIONS.—The term ‘eligible in-
25 dividual’ shall not include—

1 “(i) an individual who is eligible for
2 medical assistance under part A consisting
3 of acute medical services described in sec-
4 tion 1931(b)(1);

5 “(ii) an individual who is entitled to
6 benefits under part A of title XVIII;

7 “(iii) an individual with respect to
8 whom an employer contribution toward the
9 premium for coverage under the certified
10 health plan in which the individual is en-
11 rolled is paid (or offered to be paid) on be-
12 half of such individual; and

13 “(iv) an individual who is an inmate
14 of a public institution (except as a patient
15 of a medical institution).

16 “(C) **LAWFUL ALIEN.**—The term ‘lawful
17 alien’ means an individual who is—

18 “(i) an alien lawfully admitted for
19 permanent residence,

20 “(ii) an asylee,

21 “(iii) a refugee,

22 “(iv) an alien whose deportation has
23 been withheld under section 243(h) of the
24 Immigration and Nationality Act, or

1 “(v) a parolee who has been paroled
2 for a period of 1 year or more.

3 “(4) FAMILY.—The term ‘family’—

4 “(A) means, with respect to an eligible in-
5 dividual who is not a child, the individual; and

6 “(B) includes the following persons (if
7 any):

8 “(i) The individual’s spouse if the
9 spouse is an eligible individual.

10 “(ii) The individual’s children (and, if
11 applicable, the children of the individual’s
12 spouse) if they are eligible individuals.

13 “(5) POVERTY LINE.—The term ‘poverty line’
14 means the income official poverty line (as defined by
15 the Office of Management and Budget, and revised
16 annually in accordance with section 673(2) of the
17 Omnibus Budget Reconciliation Act of 1981) that—

18 “(A) in the case of a family of less than
19 five individuals, is applicable to a family of the
20 size involved; and

21 “(B) in the case of a family of more than
22 four individuals, is applicable to a family of
23 four persons.

1 **“Subpart 2—Deficit Neutral Spending on Premium**
 2 **Assistance**

3 **“SEC. 1960. ENSURING DEFICIT NEUTRAL SPENDING ON**
 4 **PREMIUM ASSISTANCE.**

5 “(a) LIMITATION ON PREMIUM ASSISTANCE SPEND-
 6 ING.—In each fiscal year (beginning with 1996), spending
 7 for premium assistance shall be limited to the excess of—

8 “(1) the aggregate limitation described in sub-
 9 section (b), over

10 “(2) mandatory expenditures under title XVIII
 11 and part A of XIX, including any offsetting receipts
 12 required under title XVIII but excluding any discre-
 13 tionary expenditures under such title or part A of
 14 title XIX.

15 “(b) AGGREGATE LIMITATION.—

16 “(1) IN GENERAL.—For purposes of this sec-
 17 tion the aggregate limitation shall be—

18 “(A) for fiscal year 1996, \$282 billion

19 “(B) for fiscal year 1997, \$311 billion

20 “(C) for fiscal year 1998, \$341 billion

21 “(D) for fiscal year 1999, \$381 billion

22 “(E) for fiscal year 2000, \$421 billion

23 “(F) for fiscal year 2001, \$466 billion

24 “(G) for fiscal year 2002, \$518 billion

25 “(H) for fiscal year 2003, \$576 billion

26 “(I) for fiscal year 2004, \$640 billion; and

1 “(J) for fiscal year 2005 and succeeding
2 fiscal years, the amount in the preceding fiscal
3 year increased by the growth in the per capita
4 Gross Domestic Product.

5 “(2) ADJUSTMENT BASED ON MID-SESSION RE-
6 VIEW OF ESTIMATES.—If it is determined under the
7 mid-session review of estimates under subsection (d)
8 that expenditures under the provisions of title
9 XVIII, part A of title XIX, and the premium assist-
10 ance program under subpart 1 for the preceding fis-
11 cal year exceeded the estimates for such fiscal year
12 then the amount under paragraph (1) for the up-
13 coming fiscal year shall be decreased by the amount
14 of such excess.

15 “(c) PRESIDENT’S BUDGET TO INCLUDE PREMIUM
16 ASSISTANCE ESTIMATES.—

17 “(1) IN GENERAL.—When the President sub-
18 mits a budget (as required by section 1105 of title
19 31), the President shall include in such budget—

20 “(A) estimates of expenditures under the
21 provisions of title XVIII, part A of title XIX,
22 and the premium assistance program under
23 subpart 1 otherwise provided under such provi-
24 sions without regard to this section; and

1 “(B) a comparison of the total of such ex-
 2 penditures with the aggregate limitation estab-
 3 lished under subsection (b); and

4 “(C) estimates of the income eligibility
 5 amount (described in subsection (d)(1)) and
 6 subsidy percentages (described in subsection
 7 (d)(3)) under the premium assistance program
 8 that are necessary to comply with enforcement
 9 of the limitation on premium assistance spend-
 10 ing under subsection (d).

11 “(2) FISCAL YEARS COVERED.—The President
 12 shall submit such estimates for the upcoming fiscal
 13 year and the following 4 fiscal years beginning with
 14 the budget submitted for fiscal year 1996, and

15 “(A) beginning with the budget for fiscal
 16 year 1997, the current fiscal year; and

17 “(B) beginning with the budget for fiscal
 18 year 1998, the current fiscal year and the pre-
 19 ceding fiscal year.

20 “(d) ENFORCING THE LIMITATION ON PREMIUM AS-
 21 SISTANCE SPENDING.—

22 “(1) MID-SESSION REVIEW ESTIMATES.—As
 23 part the President’s supplemental summary provid-
 24 ing revised estimates of the budget (commonly called
 25 the ‘mid-session review of the budget’), the Presi-

1 dent shall issue estimates of expenditures under title
2 XVIII, part A of XIX, and the premium assistance
3 program under subpart 1 otherwise provided without
4 regard to this section for—

5 “(A) the upcoming fiscal year;

6 “(B) the current fiscal year (beginning
7 with the mid-session review for the fiscal year
8 1997 budget); and

9 “(C) the preceding fiscal year (beginning
10 with the mid-session review for the fiscal year
11 1998 budget).

12 “(2) MAXIMUM INCOME ELIGIBILITY.—Based
13 on the estimates provided pursuant to paragraph
14 (1), the Director of the Office of Management and
15 Budget (referred to in this section as the “Direc-
16 tor”) shall, after consultation with the Secretary, de-
17 termine the maximum income amount (expressed as
18 a percentage of the poverty line (as defined in sec-
19 tion 1957(5))) under which families may be eligible
20 for premium assistance in the next calendar year
21 such that spending for premium assistance in the
22 upcoming fiscal year does not exceed the limitation
23 established under subsection (b), except that the Di-
24 rector shall not establish a maximum income amount

1 for the next calendar year that is below such amount
 2 for the current calendar year.

3 “(3) OTHER MODIFICATIONS.—If maintaining
 4 the maximum income amount at the level that ap-
 5 plies in the current calendar year in the next cal-
 6 endar year would cause spending to exceed the limi-
 7 tation for premium assistance in the upcoming fiscal
 8 year, the Director shall order a uniform percentage
 9 reduction in the subsidy percentages specified under
 10 section 1952(a)(3) to ensure spending does not ex-
 11 ceed the limitation.”.

12 (c) CONFORMING AMENDMENTS.—(1) Title XIX of
 13 the Social Security Act (42 U.S.C. 1396 et seq.) is amend-
 14 ed by striking the title and inserting the following:

15 **“TITLE XIX—MEDICAL ASSIST-**
 16 **ANCE PROGRAMS AND STATE**
 17 **PROGRAMS FOR PREMIUM**
 18 **ASSISTANCE**

19 **“PART A—GRANTS TO STATES FOR MEDICAL**
 20 **ASSISTANCE PROGRAMS”.**

21 (2) Title XIX of the Social Security Act (42 U.S.C.
 22 1396 et seq.) is amended by striking each reference to
 23 “this title” and inserting “this part”.

1 **TITLE II—HEALTH INSURANCE**
 2 **AND DELIVERY SYSTEMS RE-**
 3 **FORM**

4 **Subtitle A—Federal Standards for**
 5 **State Certification Programs**

6 **SEC. 201. STATE PLAN FOR CERTIFICATION OF HEALTH IN-**
 7 **SURANCE AND DELIVERY SYSTEMS.**

8 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
 9 1902(a) of the Social Security Act (42 U.S.C. 1396a(a))
 10 is amended by striking “and” at the end of paragraph
 11 (61), by striking the period at the end of paragraph (62)
 12 and inserting “; and”, and by inserting after paragraph
 13 (62) the following new paragraph:

14 “(63) provide that the State is a participating State
 15 under title XXI.”

16 (b) PARTICIPATING STATE PLAN FOR CERTIFI-
 17 CATION OF HEALTH INSURANCE AND DELIVERY SYS-
 18 TEMS.—The Social Security Act is amended by adding at
 19 the end the following new title:

20 **“TITLE XXI—STATE PLAN FOR**
 21 **CERTIFICATION OF HEALTH**
 22 **INSURANCE AND DELIVERY**
 23 **SYSTEMS**

24 “TABLE OF CONTENTS

“Subtitle A—Participating State Program

“PART I—GENERAL RESPONSIBILITIES

- “Sec. 21001. Establishment of participating State programs.
- “Sec. 21002. Access to standardized health care coverage.
- “Sec. 21003. General definitions relating to health plans.

“PART II—CERTIFICATION AND CONSUMER VALUE

- “Sec. 21011. Certification of health plans.
- “Sec. 21012. Consumer value program.
- “Sec. 21013. Establishment of community rating areas.
- “Sec. 21014. Risk adjustment programs.
- “Sec. 21015. Specification of initial general enrollment period.

“PART III—TREATMENT OF CERTAIN STATE LAWS

- “Sec. 21021. Preemption of certain State law restrictions on health plans.
- “Sec. 21022. Preemption from State benefit mandates.
- “Sec. 21023. Preemption of State law regulating utilization management and review.
- “Sec. 21024. State laws regarding end of life treatment.

“PART IV—DEFINITIONS AND RULES

- “Sec. 21100. Definitions and rules of general application.

“Subtitle B—Standards for Reform

“PART I—ESTABLISHMENT AND APPLICATION OF STANDARDS AND GUIDELINES

- “Sec. 21101. Insurance reform standards.
- “Sec. 21102. Delivery system guidelines.
- “Sec. 21103. Consumer value program.
- “Sec. 21104. Risk adjustment programs.
- “Sec. 21105. Standards and guidelines by Secretary of Labor.
- “Sec. 21106. General rules.

“PART II—INSURANCE REFORM STANDARDS APPLICABLE TO HEALTH PLANS

- “Sec. 21111. Guaranteed issue and renewal.
- “Sec. 21112. Enrollment.
- “Sec. 21113. Nondiscrimination based on health status.
- “Sec. 21114. Rating limitations for community-rated market.
- “Sec. 21115. Benefits offered.
- “Sec. 21116. Risk adjustment.
- “Sec. 21117. Prohibition of discrimination.

“PART III—MINIMUM DELIVERY SYSTEM GUIDELINES APPLICABLE TO HEALTH PLANS

- “Sec. 21121. Minimum delivery system guidelines.

“Subtitle C—Expanded Access to Health Plans

“PART I—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

- “Sec. 21201. Establishment and organization.

“PART II—ACCESS THROUGH FEHBP

“Sec. 21211. Small business participation in FEHBP.

“PART III—ACCESS THROUGH ASSOCIATION PLANS

“SUBPART A—QUALIFIED ASSOCIATION PLANS

“Sec. 21221. Treatment of qualified association plans.

“Sec. 21222. Qualified association plan defined.

“Sec. 21223. Definitions and special rules.

“SUBPART B—SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND
COOPERATIVE PLANS

“Sec. 21225. Special rule for church, multiemployer, and cooperative plans.

“PART IV—ACCESS THROUGH EMPLOYERS

“Sec. 21231. General employer responsibilities.

“Sec. 21232. Development of large employer purchasing groups.

“Sec. 21233. Report to employees on employer health care contributions.

“Sec. 21334. Employer may not discriminate against subsidy eligible individuals.

“Sec. 21235. Enforcement.

1 **“Subtitle A—Participating State**
2 **Program**

3 **“PART I—GENERAL RESPONSIBILITIES**

4 "SEC. 21001. ESTABLISHMENT OF PARTICIPATING STATE
5 PROGRAMS.

6 “A State shall be a participating State for purposes
7 of this title if such State establishes by not later than Jan-
8 uary 1, 1998, a certification and consumer value program
9 (in this title referred to as a ‘State program’) to carry
10 out participating State responsibilities specified in this
11 title.

12 **“SEC. 21002. ACCESS TO STANDARDIZED HEALTH CARE**
13 **COVERAGE.**

14 “(a) ACCESS TO STANDARDIZED COVERAGE.—

1 “(1) IN GENERAL.—Except as provided in para-
 2 graph (2), a State program shall require that each
 3 insured health plan issued, sold, offered for sale, or
 4 operated in the State shall be certified by the appro-
 5 priate certifying authority as a certified health plan.

6 “(2) FEDERAL CERTIFICATION OF SELF-IN-
 7 SURED PLANS.—In the case of self-insured health
 8 plans, the Secretary of Labor shall carry out activi-
 9 ties under this title in the same manner as a partici-
 10 pating State would carry out such activities with re-
 11 spect to an insured health plan subject to this title.

12 “(b) ACCESS TO AFFORDABLE COVERAGE.—A State
 13 program shall require the following:

14 “(1) COMMUNITY RATING.—

15 “(A) IN GENERAL.—Except as provided in
 16 subparagraph (B), all health plans shall be
 17 community-rated health plans which cover only
 18 community-rated individuals.

19 “(B) EXPERIENCE-RATED HEALTH
 20 PLANS.—Subparagraph (A) shall not apply to
 21 any health plan which—

22 “(i) is a self-insured health plan of an
 23 experience-rated employer, or

24 “(ii) is an insured health plan which
 25 is experience-rated,

1 but any such plan may cover only experience-
2 rated individuals.

3 “(2) SUBSIDIZED COVERAGE.—Individuals shall
4 be entitled to such premium assistance as is pro-
5 vided under the program described in part B of title
6 XIX.

7 “(c) ACCESS THROUGH HEALTH PLAN SPONSORS.—
8 Subject to the requirements of part II of subtitle B—

9 “(1) a State program shall require each health
10 plan sponsor to make available to each community-
11 rated individual the opportunity to enroll, directly or
12 through a purchasing cooperative, in a certified
13 health plan which provides the FedMed benefits
14 package established under section 21115(b); and

15 “(2) each health plan sponsor may offer any
16 other certified health plan which provides any other
17 health benefits package, including a supplemental
18 benefit package to the FedMed benefits package, but
19 may not require an individual or group to purchase
20 supplemental coverage or link the pricing of the
21 FedMed benefits package to the purchase of a sup-
22 plemental benefits package.

23 **“SEC. 21003. GENERAL DEFINITIONS RELATING TO HEALTH**
24 **PLANS.**

25 “(a) HEALTH PLAN.—For purposes of this title—

1 “(1) IN GENERAL.—The term ‘health plan’
2 means any plan or arrangement which provides, or
3 pays the cost of, health benefits. Such term does not
4 include the following, or any combination thereof:

5 “(A) Coverage only for accidental death,
6 dismemberment, dental, or vision.

7 “(B) Coverage providing wages or pay-
8 ments in lieu of wages for any period during
9 which the employee is absent from work on ac-
10 count of sickness or injury.

11 “(C) A medicare supplemental policy (as
12 defined in section 1882(g)(1)).

13 “(D) Coverage issued as a supplement to
14 liability insurance.

15 “(E) Worker’s compensation or similar in-
16 surance.

17 “(F) Automobile medical-payment insur-
18 ance.

19 “(G) A long-term care insurance policy, in-
20 cluding a nursing home fixed indemnity policy
21 (unless the Secretary determines that such a
22 policy provides sufficiently comprehensive cov-
23 erage of a benefit so that it should be treated
24 as a health plan).

25 “(H) An equivalent health care program.

1 “(I) Any plan or arrangement not de-
2 scribed in any preceding subparagraph which
3 provides for benefit payments, on a periodic
4 basis, for a specified disease or illness or period
5 of hospitalization without regard to the costs in-
6 curred or services rendered during the period to
7 which the payments relate.

8 “(J) Such other plan or arrangement as
9 the Secretary determines is not a health plan.

10 “(2) INSURED HEALTH PLAN.—

11 “(A) IN GENERAL.—The term ‘insured
12 health plan’ means any health plan which is a
13 hospital or medical service policy or certificate,
14 hospital or medical service plan contract, or
15 health maintenance organization group contract
16 offered by an insurer.

17 “(B) INSURER.—The term ‘insurer’
18 means—

19 “(i) a licensed insurance company,

20 “(ii) a prepaid hospital or medical
21 service plan,

22 “(iii) a health maintenance organiza-
23 tion, or

24 “(iv) any other similar entity,

1 which is engaged in the business of providing a
2 plan of health insurance or health benefits or
3 services.

4 “(3) SELF-INSURED HEALTH PLAN.—The term
5 ‘self-insured health plan’ means an employee welfare
6 benefit plan, church plan, government plan, or other
7 arrangement which—

8 “(A) provides health benefits funded in a
9 manner other than through the purchase of one
10 or more insured health plans, but

11 “(B) does not include any coverage or in-
12 surance described in subparagraphs (A)
13 through (J) of paragraph (1).

14 “(b) CERTIFIED HEALTH PLAN.—For purposes of
15 this title, the term ‘certified health plan’ means a health
16 plan which is certified by the appropriate certifying au-
17 thority as meeting the applicable requirements of this title.

18 “(c) TERMS AND RULES RELATING TO COMMUNITY
19 AND EXPERIENCE RATING.—For purposes of this title—

20 “(1) COMMUNITY-RATED HEALTH PLAN.—The
21 term ‘community-rated health plan’ means a health
22 plan which meets the requirements of section 21114.

23 “(2) COMMUNITY-RATED INDIVIDUAL.—The
24 term ‘community-rated individual’ means an individ-
25 ual—

1 “(A) who is not an experience-rated indi-
2 vidual, or

3 “(B) who is an experience-rated individual
4 (determined without regard to this subpara-
5 graph) and whose employer does not provide an
6 employer-subsidized certified health plan.

7 Such term includes the spouse and dependents of
8 such individual.

9 “(3) EXPERIENCE-RATED INDIVIDUAL.—The
10 term ‘experience-rated individual’ means an individ-
11 ual who is an employee of an experience-rated em-
12 ployer. Such term includes the spouse and depend-
13 ents of such individual.

14 “(4) EXPERIENCE-RATED EMPLOYER.—

15 “(A) IN GENERAL.—The term ‘experience-
16 rated employer’ means—

17 “(i) in the case of a self-insured
18 health plan, any employer, and

19 “(ii) in the case of an insured health
20 plan, with respect to any calendar year,
21 any employer if, on each of 20 days during
22 the preceding calendar year (each day
23 being in a different week), such employer
24 (or any predecessor) employed more than
25 50 employees for some portion of the day.

1 “(B) CERTAIN OTHER PLANS.—Such term
2 shall include multiemployer plans, church asso-
3 ciation plans, and rural electric cooperative or
4 rural telephone cooperative association plans.

5 “(5) SPECIAL RULE FOR SPOUSES AND DE-
6 PENDENTS.—If any individual is offered coverage
7 under a health plan as the spouse or a dependent of
8 a primary enrollee of such plan, such individual shall
9 have the status of such enrollee unless such individ-
10 ual is eligible to elect other coverage and so elects.

11 **“PART II—CERTIFICATION AND CONSUMER**

12 **VALUE**

13 **“SEC. 21011. CERTIFICATION OF HEALTH PLANS.**

14 “(a) IN GENERAL.—Each State program shall pro-
15 vide for the certification of health plans as certified health
16 plans in accordance with the insurance reform standards
17 and the delivery system guidelines established by the Sec-
18 retary under subtitle B.

19 “(b) USE OF PRIVATE ENTITIES.—

20 “(1) EXPERTS.—A State shall consult with ex-
21 perts in designing and implementing a State certifi-
22 cation program under this section.

23 “(2) ACCREDITATION.—A State program may
24 provide for the use of private accreditation entities

1 in carrying out all or part of the duties under sub-
2 section (a).

3 “(c) COORDINATION OF ACTIVITIES.—In designing
4 and implementing the State certification program under
5 this section, a State shall coordinate activities by State
6 public health offices with activities of the insurance com-
7 missioner of the State, and with other relevant State agen-
8 cies, with respect to the duties and responsibilities of each
9 such entity.

10 “(d) CERTIFICATION FEES.—A State program may
11 impose appropriate certification fees on health plans seek-
12 ing certification.

13 “(e) CERTIFICATION ENFORCEMENT.—A State pro-
14 gram shall provide for the monitoring and enforcement of
15 the certification of health plans.

16 **“SEC. 21012. CONSUMER VALUE PROGRAM.**

17 “(a) ESTABLISHMENT OF PROGRAM.—Each State, in
18 accordance with minimum guidelines established by the
19 Secretary under section 21103, shall establish and operate
20 a consumer value program to provide consumers in the
21 State with comparative value information on the perform-
22 ance of all health plans in each community rating area
23 in the State. State consumer value programs under this
24 section may exceed the guidelines established by the Sec-
25 retary.

1 “(b) USE OF PRIVATE ORGANIZATIONS.—A State
2 may operate the consumer value program through a con-
3 tract with a private organization selected by the State.

4 “(c) ELIGIBILITY FOR GRANTS.—Each State with a
5 consumer value program shall be eligible for grants under
6 section 21103(b). To be eligible for such a grant, a State
7 shall prepare and submit to the Secretary an application
8 at such time, in such manner, and containing such infor-
9 mation as the Secretary may require.

10 “(d) ADDITIONAL REQUIREMENTS.—Each State pro-
11 gram shall meet the requirements specified under subtitles
12 B and C of title XI with respect to certified health plans.

13 **“SEC. 21013. ESTABLISHMENT OF COMMUNITY RATING**
14 **AREAS.**

15 “(a) ESTABLISHMENT.—Each participating State
16 under the State program shall, by not later than January
17 1, 1998, provide for the inclusion of all areas of the State
18 into 1 or more community rating areas. The program may
19 revise the boundaries of such areas from time to time con-
20 sistent with this section.

21 “(b) MULTIPLE AREAS.—With respect to a commu-
22 nity rating area—

23 “(1) no metropolitan statistical area or primary
24 metropolitan statistical area in a State may be di-

1 vided into more than 1 community rating area in
2 such State;

3 “(2) the number of individuals residing within
4 a community rating area may not be less than
5 250,000; and

6 “(3) no area incorporated into a community
7 rating area may be incorporated into another com-
8 munity rating area.

9 “(c) BOUNDARIES.—In establishing boundaries for
10 community rating areas, a participating State may not
11 discriminate on the basis of, or otherwise take into ac-
12 count, disability, health status, or perceived need for
13 health services of a particular population. Such restric-
14 tions shall not prohibit participating States from establish-
15 ing such boundaries to ensure that underserved and vul-
16 nerable populations are better served.

17 “(d) INTERSTATE AREAS.—Two or more contiguous
18 participating States may provide for the establishment of
19 a community rating area that includes adjoining areas of
20 the States so long as all areas of any metropolitan statis-
21 tical area or primary metropolitan statistical area within
22 such States are within the same community rating area.

23 **“SEC. 21014. RISK ADJUSTMENT PROGRAMS.**

24 “Each participating State under the State program
25 shall provide a risk adjustment program meeting the

1 standards developed by the Secretary under section
2 21104.

3 **“SEC. 21015. SPECIFICATION OF INITIAL GENERAL ENROLL-**
4 **MENT PERIOD.**

5 “Upon the date of the commencement of the State
6 program, the participating State shall specify for the State
7 (or for each community rating area) an initial period, of
8 not less than 90 days, during which individuals in the
9 State (or area) may enroll in certified health plans.

10 **“PART III—TREATMENT OF CERTAIN STATE**
11 **LAWS**

12 **“SEC. 21021. PREEMPTION OF CERTAIN STATE LAW RE-**
13 **STRICTIONS ON HEALTH PLANS.**

14 “Effective as of January 1, 1996—

15 “(1) a State may not prohibit or limit a health
16 plan from including incentives for enrollees to use
17 the services of participating providers;

18 “(2) a State may not prohibit or limit a health
19 plan from requiring enrollees to obtain care from
20 participating providers;

21 “(3) a State may not prohibit or limit a health
22 plan from requiring enrollees to obtain referrals for
23 specialty treatment;

1 “(4) a State may not prohibit or limit the es-
2 tablishment of different payment rates for partici-
3 pating and non-participating providers;

4 “(5) a State may not prohibit or limit a health
5 plan from limiting the number and types of partici-
6 pating providers;

7 “(6) a State may not prohibit or limit a health
8 plan from using single source suppliers for pharmacy
9 services, medical equipment, and other supplies and
10 services; and

11 “(7) a State may not prohibit or limit the cor-
12 porate practice of medicine.

13 **“SEC. 21022. PREEMPTION FROM STATE BENEFIT MAN-**
14 **DATES.**

15 “Effective as of January 1, 1996, no State shall es-
16 tablish or enforce any law or regulation that requires any
17 certified health plan to cover any specific item or service.

18 **“SEC. 21023. PREEMPTION OF STATE LAW REGULATING**
19 **UTILIZATION MANAGEMENT AND REVIEW.**

20 “Effective as of January 1, 1996, a State may not
21 regulate utilization management and review programs of
22 any health plan to the extent not provided by this title.

1 **“SEC. 21024. STATE LAWS REGARDING END OF LIFE TREAT-**
 2 **MENT.**

3 “Nothing in this title shall be construed to invalidate
 4 any State law that has the effect of preventing involuntary
 5 denial of lifesaving medical treatment when such denial
 6 would cause the involuntary death of the patient pending
 7 transfer of the patient to a health care provider willing
 8 to provide such treatment.

9 **“PART IV—DEFINITIONS AND RULES**

10 **“SEC. 21100. DEFINITIONS AND RULES OF GENERAL APPLI-**
 11 **CATION.**

12 “Except as otherwise specifically provided, in this
 13 title the following definitions and rules apply:

14 “(1) APPROPRIATE CERTIFYING AUTHORITY.—

15 The term ‘appropriate certifying authority’ means—

16 “(A) except as provided in subparagraph
 17 (B), in the case of an insured health plan, the
 18 State commissioner or superintendent of insur-
 19 ance or other State authority in the participat-
 20 ing State; or

21 “(B) in the case of a self-insured health
 22 plan, the Secretary of Labor.

23 “(2) CHURCH ASSOCIATION PLAN.—The term
 24 ‘church association plan’ means a church plan (as
 25 defined in section 414(e) of the Internal Revenue
 26 Code of 1986).

1 “(3) DELIVERY SYSTEM.—The term ‘delivery
2 system’ with respect to a health plan includes a fee-
3 for-service, use of preferred providers, staff or group
4 model health maintenance organizations, and such
5 other arrangements as the Secretary may recognize.

6 “(4) DEPENDENT.—The term ‘dependent’
7 means, with respect to any individual, any person—

8 “(A) who is a child or stepchild of the indi-
9 vidual; and

10 “(B) who is—

11 “(i) under 22 years of age (under 25
12 years of age in the case of a fulltime stu-
13 dent) and unmarried, or

14 “(ii) permanently and totally disabled
15 (within the meaning of section
16 151(c)(5)(C) of such Code).

17 “(5) EMPLOYER, EMPLOYEE, AND EMPLOY-
18 MENT DEFINED.—

19 “(A) IN GENERAL.—Except as otherwise
20 provided in this subtitle—

21 “(i) the term ‘employment’ has the
22 meaning given such term under section
23 3121 of the Internal Revenue Code of
24 1986,

1 “(ii) the term ‘employee’ has the
2 meaning given such term under section
3 3121 of such Code, subject to the provi-
4 sions of chapter 25 of such Code, and

5 “(iii) the term ‘employer’ has the
6 same meaning as the term “employer” as
7 used in such section 3121.

8 “(B) EXCEPTIONS.—For purposes of sub-
9 paragraph (A)—

10 “(i) EMPLOYMENT.—

11 “(I) EMPLOYMENT INCLUDED.—
12 Paragraphs (1), (2), (5), (7) (other
13 than clauses (i) through (iv) of sub-
14 paragraph (C) and clauses (i) through
15 (v) of subparagraph (F)), (8), (9),
16 (10), (11), (13), (15), (18), and (19)
17 of section 3121(b) of the Internal
18 Revenue Code of 1986 shall not apply.

19 “(II) EXCLUSION OF SEASONAL
20 OR TEMPORARY.—Employment shall
21 not include seasonal or temporary
22 services performed for an employer for
23 less than 6 months in a calendar year.

24 “(ii) EMPLOYEES.—

1 “(I) TREATMENT OF SELF-EM-
2 PLOYED.—The term ‘employee’ in-
3 cludes a self-employed individual.

4 “(II) EXCLUSION OF CERTAIN
5 FOREIGN EMPLOYMENT.—The term
6 ‘employee’ does not include an individ-
7 ual with respect to service, if the indi-
8 vidual is not a citizen or resident of
9 the United States and the service is
10 performed outside the United States.

11 “(C) AGGREGATION RULES FOR EMPLOY-
12 ERS.—For purposes of this title—

13 “(i) all employers treated as a single
14 employer under subsection (a) or (b) of
15 section 52 of the Internal Revenue Code of
16 1986 shall be treated as a single employer,
17 and

18 “(ii) under regulations of the Sec-
19 retary of the Treasury, all employees of or-
20 ganizations which are under common con-
21 trol with one or more organizations which
22 are exempt from income tax under subtitle
23 A of the Internal Revenue Code of 1986
24 shall be treated as employed by a single
25 employer.

1 The regulations prescribed under clause (ii)
2 shall be based on principles similar to the prin-
3 ciples which apply to taxable organizations
4 under clause (i).

5 “(6) EQUIVALENT HEALTH CARE PROGRAM.—

6 The term ‘equivalent health care program’ means—

7 “(A) part A or part B of the medicare pro-
8 gram under title XVIII of the Social Security
9 Act,

10 “(B) the medicaid program under title
11 XIX of the Social Security Act,

12 “(C) the health care program for active
13 military personnel under title 10, United States
14 Code,

15 “(D) the veterans health care program
16 under chapter 17 of title 38, United States
17 Code,

18 “(E) the Civilian Health and Medical Pro-
19 gram of the Uniformed Services (CHAMPUS),
20 as defined in section 1073(4) of title 10, United
21 States Code, and

22 “(F) the Indian health service program
23 under the Indian Health Care Improvement Act
24 (25 U.S.C. 1601 et seq.).

1 “(7) FAMILY.—The term ‘family’ includes an
2 individual, the individual’s spouse, and the individ-
3 ual’s dependents (if any), as defined in paragraph
4 (4).

5 “(8) HEALTH PLAN SPONSOR.—The term
6 ‘health plan sponsor’ means, with respect to—

7 “(A) an insured health plan, the insurer,
8 and

9 “(B) a self-insured health plan, the experi-
10 ence-rated employer sponsor.

11 “(9) MULTIEMPLOYER PLAN.—The term ‘multi-
12 employer plan’ has the meaning given such term in
13 section 3(37) of the Employee Retirement Income
14 Security Act of 1974, and includes any plan that is
15 treated as such a plan under title I of such Act.

16 “(10) NAIC.—The term ‘NAIC’ means the Na-
17 tional Association of Insurance Commissioners.

18 “(11) PARTICIPATING STATE.—The term ‘par-
19 ticipating State’ means a State establishing a State
20 program under this title.

21 “(12) PURCHASING COOPERATIVE.—The term
22 ‘purchasing cooperative’ means a health insurance
23 purchasing cooperative described in section 21201.

24 “(13) RURAL ELECTRIC COOPERATIVE.—The
25 term ‘rural electric cooperative’ has the meaning

1 given such term in section 3(40)(A)(iv) of the Em-
 2 ployee Retirement Income Security Act of 1974.

3 “(14) RURAL TELEPHONE COOPERATIVE ASSO-
 4 CIATIONS.—The term ‘rural telephone cooperative
 5 association’ has the meaning given such term in sec-
 6 tion 3(40)(A)(v) of the Employee Retirement Income
 7 Security Act of 1974.

8 “(15) SECRETARY.—The term ‘Secretary’
 9 means the Secretary of Health and Human Services
 10 or the Secretary’s delegate.

11 “(16) STATE.—The term ‘State’ means each of
 12 the several States, the District of Columbia, the
 13 Commonwealth of Puerto Rico, the United States
 14 Virgin Islands, Guam, American Samoa, and the
 15 Commonwealth of the Northern Mariana Islands.

16 **“Subtitle B—Standards for Reform**

17 **“PART I—ESTABLISHMENT AND APPLICATION OF** 18 **STANDARDS AND GUIDELINES**

19 **“SEC. 21101. INSURANCE REFORM STANDARDS.**

20 “Except as provided in section 21105, the Secretary,
 21 in consultation with the NAIC, shall develop and publish
 22 specific standards and evaluation criteria to implement the
 23 insurance reform standards specified in part II by not
 24 later than 9 months after the date of the enactment of
 25 this title.

1 **“SEC. 21102. DELIVERY SYSTEM GUIDELINES.**

2 “(a) ESTABLISHMENT.—Except as provided in sec-
3 tion 21105, not later than 9 months after the date of en-
4 actment of this title, the Secretary, in consultation with
5 the NAIC and other organizations with expertise in the
6 areas of quality assurance (including the Joint Commis-
7 sion on Accreditation of Health Care Organizations, the
8 National Committee for Quality Assurance, and peer re-
9 view organizations), shall establish minimum guidelines
10 specified in part III for the certification of health plan
11 delivery systems and the enforcement of such guidelines.

12 “(b) MINIMUM GUIDELINES.—Each participating
13 State through the State program may exceed the guide-
14 lines established by the Secretary under this section.

15 **“SEC. 21103. CONSUMER VALUE PROGRAM.**

16 “(a) DEVELOPMENT OF GUIDELINES.—The Sec-
17 retary shall develop and distribute to participating States
18 model minimum guidelines for the establishment of State
19 consumer value programs under section 21012. Such
20 guidelines shall include a description of a consumer report
21 card that is designed to standardize consumer information
22 among all States concerning certified health plans.

23 “(b) GRANT PROGRAM.—The Secretary may award
24 demonstration grants to States that establish consumer
25 value programs, with priority given by the Secretary to

1 States that exceed the minimum guidelines established by
2 the Secretary under this section.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated such sums as are nec-
5 essary to carry out the purposes of this section.

6 **“SEC. 21104. RISK ADJUSTMENT PROGRAMS.**

7 “Except as provided in section 21105, the Secretary
8 shall develop standards for participating States to provide
9 risk adjustment programs for participation by community-
10 rated insured health plans and reinsurers of self-insured
11 health plans sponsored by employers which are not experi-
12 ence-rated employers as described in section 21116(b).

13 **“SEC. 21105. STANDARDS AND GUIDELINES BY SECRETARY**
14 **OF LABOR.**

15 “The Secretary of Labor shall develop for self-insured
16 health plans appropriate insurance reform standards and
17 minimum delivery system guidelines similar to such stand-
18 ards and guidelines described in sections 21101 and
19 21102.

20 **“SEC. 21106. GENERAL RULES.**

21 “(a) CONSTRUCTION.—Whenever in this subtitle a
22 requirement or standard is imposed on a health plan, the
23 requirement or standard is deemed to have been imposed
24 on the insurer or sponsor of the plan in relation to that
25 plan.

1 “(b) USE OF INTERIM, FINAL REGULATIONS.—In
 2 order to permit the timely implementation of the provi-
 3 sions of this title, the Secretary and the Secretary of
 4 Labor are each authorized to issue regulations under this
 5 title on an interim basis that become final on the date
 6 of publication, subject to change based on subsequent pub-
 7 lic comment.

8 “(c) REFERENCE TO REFORM STANDARDS.—For
 9 purposes of this title, the term ‘reform standards’ means
 10 the standards developed under this subtitle and applicable
 11 under part II.

12 **“PART II—INSURANCE REFORM STANDARDS**

13 **APPLICABLE TO HEALTH PLANS**

14 **“SEC. 21111. GUARANTEED ISSUE AND RENEWAL.**

15 “(a) ISSUE.—

16 “(1) IN GENERAL.—Except as otherwise pro-
 17 vided in this section, a health plan sponsor—

18 “(A) offering a community-rated health
 19 plan shall offer such plan to any community-
 20 rated individual applying for coverage; and

21 “(B) offering an experience-rated health
 22 plan or a self-insured health plan shall offer
 23 such plan to any experience-rated individual eli-
 24 gible for coverage under the plan through the
 25 individual’s experience-rated employer.

1 “(2) AVAILABILITY.—

2 “(A) IN GENERAL.—A community-rated
3 health plan shall be made available throughout
4 the entire community rating area in which such
5 plan is offered, including through any purchas-
6 ing cooperative choosing to offer such plan.

7 “(B) GEOGRAPHIC LIMITATIONS.—A com-
8 munity-rated health plan may deny coverage
9 under the plan to a community-rated individual
10 who resides outside the community rating area
11 in which such plan is offered, but only if such
12 denial is applied uniformly, without regard to
13 health status or insurability of individuals.

14 “(C) APPLICABILITY TO NETWORK
15 PLANS.—Subparagraphs (A) and (B) shall each
16 be applied to a community-rated health plan
17 using a staff or group model health mainte-
18 nance organization or other network delivery
19 system by substituting ‘service area determined
20 by the appropriate certifying authority’ for
21 ‘community rating area’.

22 “(3) APPLICATION OF CAPACITY LIMITS.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graph (B), an insured health plan may apply to

1 the appropriate certifying authority to cease en-
2 rolling individuals under the plan if—

3 “(i) the plan ceases to enroll any new
4 individuals; and

5 “(ii) the plan can demonstrate to the
6 applicable certifying authority that its fi-
7 nancial or provider capacity to serve pre-
8 viously covered groups or individuals (and
9 additional individuals who will be expected
10 to enroll because of affiliation with such
11 previously covered groups or individuals)
12 will be impaired if it is required to enroll
13 other individuals.

14 “(B) FIRST-COME-FIRST-SERVED.—An in-
15 sured health plan is only eligible to exercise the
16 limitations provided for in subparagraph (A) if
17 such plan provides for enrollment of individuals
18 on a first-come-first-served basis (except in the
19 case of additional individuals described in sub-
20 paragraph (A)(ii)).

21 “(b) RENEWAL.—

22 “(1) IN GENERAL.—Except as provided in para-
23 graphs (2) and (3), a health plan that is issued to
24 an individual shall be renewed at the option of the
25 individual.

1 “(2) GROUNDS FOR REFUSAL TO RENEW.—A
2 health plan sponsor may refuse to renew, or may
3 terminate, a health plan under this title only for—

4 “(A) nonpayment of premiums;

5 “(B) fraud on the part of the individual; or

6 “(C) misrepresentation of material facts on
7 the part of the individual relating to an applica-
8 tion for coverage or claim for benefits.

9 “(3) EXIT FROM MARKET.—

10 “(A) IN GENERAL.—An insurer shall
11 renew an insured health plan through a particu-
12 lar type of delivery system (as defined in sec-
13 tion 21100) with respect to a community-rated
14 employer or community-rated individual, unless
15 such insurer—

16 “(i) elects not to renew all of its insured
17 health plans using such delivery system issued
18 to all such employers and individuals in a State;
19 and

20 “(ii) provides notice to the appropriate cer-
21 tifying authority and to each such employer and
22 individual covered under the plan of such termi-
23 nation at least 180 days before the date of expi-
24 ration of the plan.

1 “(B) PROHIBITION ON MARKET RE-
 2 ENTRY.—In the case of such a termination,
 3 such insurer may not provide for the issuance
 4 of any insured health plan using such a delivery
 5 system to a community-rated employer or com-
 6 munity-rated individual in such State during
 7 the 5-year period beginning on the date of the
 8 termination of the last plan not so renewed.

9 “(c) CERTAIN EXCLUDED PLANS.—The provisions of
 10 this section, other than subsections (b) and (e)(2)(B),
 11 shall not apply to any religious fraternal benefit society
 12 in existence as of September 1993, which bears the risk
 13 of providing insurance to its members, and which is an
 14 organization described in section 501(c)(8) of the Internal
 15 Revenue Code of 1986 which is exempt from taxation
 16 under section 501(a) of such Code.

17 **“SEC. 21112. ENROLLMENT.**

18 “(a) ENROLLMENT PROCESS.—A health plan shall
 19 establish an enrollment process which consists of—

20 “(A) a general annual enrollment period of
 21 at least 30 days; and

22 “(B) special enrollment periods for
 23 changes in enrollment,

24 as specified by the reform standards, which shall in-
 25 clude the circumstances under which such special en-

1 rollment periods are required and the duration of
2 such periods.

3 “(b) COMMENCEMENT OF COVERAGE.—

4 “(1) WAITING PERIODS.—An insurer or an em-
5 ployer may impose a waiting period of not more
6 than 30 days for coverage for a reasonable time nec-
7 essary to process an enrollment.

8 “(2) NEWBORNS.—In the event of the birth or
9 adoption of a child of an enrollee, coverage of such
10 child under such enrollee’s health plan (regardless of
11 the class of enrollment) shall begin on the date of
12 such birth or adoption and shall continue, in the ab-
13 sence of any enrollment of such child during a spe-
14 cial enrollment period provided under subsection
15 (a)(1)(C), for at least 45 days.

16 **“SEC. 21113. NONDISCRIMINATION BASED ON HEALTH STA-**
17 **TUS.**

18 “(a) IN GENERAL.—Except as provided under sub-
19 section (b), a health plan may not—

20 “(1) deny, limit, or condition the coverage
21 under (or benefits of) the plan; and

22 “(2) in the case of an experience-rated health
23 plan, vary the premium,

24 based on the health status, medical condition, claims expe-
25 rience, receipt of health care, medical history, anticipated

1 need for health care expenses, disability, or lack of evi-
2 dence of insurability, of an individual.

3 “(b) TREATMENT OF PREEXISTING CONDITION EX-
4 CLUSIONS FOR ALL SERVICES.—

5 “(1) IN GENERAL.—Subject to paragraph (4), a
6 health plan may impose a limitation or exclusion of
7 benefits relating to treatment of a condition based
8 on the fact that the condition preexisted the effective
9 date of the plan with respect to an individual enroll-
10 ing as a member of a group only if—

11 “(A) the condition was diagnosed or treat-
12 ed during the 3-month period ending on the day
13 before the date of enrollment under the plan;

14 “(B) the limitation or exclusion extends for
15 a period not more than 6 months after the date
16 of enrollment under the plan;

17 “(C) the limitation or exclusion does not
18 apply to an individual who, as of the date of
19 birth, was covered under the plan; or

20 “(D) the limitation or exclusion does not
21 apply to pregnancy.

22 “(2) CREDITING OF PREVIOUS COVERAGE.—A
23 health plan shall provide that if an individual under
24 such plan is in a period of continuous coverage as
25 of the date of enrollment under such plan, any pe-

1 riod of exclusion of coverage with respect to a pre-
2 existing condition shall be reduced by 1 month for
3 each month in the period of continuous coverage.

4 “(3) DEFINITIONS.—As used in this subsection:

5 “(A) PERIOD OF CONTINUOUS COV-
6 ERAGE.—The term ‘period of continuous cov-
7 erage’ means the period beginning on the date
8 an individual is enrolled under a certified health
9 plan or an equivalent health care program and
10 ends on the date the individual is not so en-
11 rolled for a continuous period of more than 3
12 months.

13 “(B) PREEXISTING CONDITION.—The term
14 ‘preexisting condition’ means, with respect to
15 coverage under a health plan, a condition which
16 was diagnosed, or which was treated, within the
17 3-month period ending on the day before the
18 date of enrollment (without regard to any wait-
19 ing period).

20 “(4) SPECIAL RULES FOR INDIVIDUALS.—In
21 the case of an individual who is not enrolling as a
22 member of a group in a health plan—

23 “(A) any reference to 3 months in para-
24 graph (1)(A) is deemed a reference to 6
25 months,

1 “(B) any reference to 6 months in para-
 2 graphs (1)(B) and (2) is deemed a reference to
 3 12 months, and

4 “(C) any reference to 3-month period in
 5 paragraph (3)(B) is deemed a reference to 6-
 6 month period.

7 “(5) PROHIBITION ON PREEXISTING CONDITION
 8 EXCLUSION DURING AMNESTY PERIOD.—

9 “(A) IN GENERAL.—This subsection shall
 10 not apply during an initial enrollment period
 11 described in section 21015.

12 “(B) CAPACITY LIMITATION.—The partici-
 13 pating State may establish a limit on the num-
 14 ber of new enrollees a health plan must accept
 15 during the period described in subparagraph
 16 (A) based on the plan’s share of the applicable
 17 community-rated or experience-rated popu-
 18 lation.

19 **“SEC. 21114. RATING LIMITATIONS FOR COMMUNITY-RATED**
 20 **MARKET.**

21 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-
 22 MUNITY-RATED INDIVIDUALS.—Each community-rated
 23 health plan shall establish within each community rating
 24 area in which the plan is to be offered a standard premium
 25 for individual enrollment for each benefits package of the

1 plan, including the FedMed benefits package established
2 under section 21115(b).

3 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
4 ING AREAS.—

5 “(1) IN GENERAL.—Subject to paragraphs (2),
6 (3), and (4), the standard premium for each package
7 described in subsection (a) for all community-rated
8 individuals within a community rating area shall be
9 the same and shall not include the costs of premium
10 processing, enrollment, and marketing that would
11 vary depending on whether the method of enrollment
12 is through a purchasing cooperative, or directly
13 through a health plan sponsor, an employer, or a
14 broker.

15 “(2) APPLICATION TO ENROLLEES.—

16 “(A) IN GENERAL.—The premium charged
17 for coverage in a community-rated health plan
18 shall be the product of—

19 “(i) the standard premium (estab-
20 lished under paragraph (1));

21 “(ii) in the case of enrollment other
22 than individual enrollment, the family ad-
23 justment factor specified under subpara-
24 graph (B); and

1 “(iii) the age adjustment factor (spec-
2 ified under subparagraph (C)).

3 “(B) FAMILY ADJUSTMENT FACTOR.—The
4 reform standards shall specify family adjust-
5 ment factors that reflect the relative actuarial
6 costs of benefit packages based on family class-
7 es of enrollment (as compared with such costs
8 for individual enrollment).

9 “(C) AGE ADJUSTMENT FACTOR.—The re-
10 form standards shall specify uniform age cat-
11 egories for age adjustment factors that reflect
12 the relative actuarial costs of benefit packages
13 among enrollees. For individuals who have at-
14 tained age 18 but not age 65, the highest age
15 adjustment factor may not exceed the lowest
16 age adjustment factor by—

17 “(i) 4 times for the first 3 years be-
18 ginning with the first year of certification
19 by the appropriate certifying authority,
20 and

21 (ii) 3 times for years thereafter.

22 “(3) ADMINISTRATIVE CHARGES.—

23 “(A) IN GENERAL.—In accordance with
24 the reform standards, a community-rated health
25 plan may add a separately-stated administrative

1 charge not to exceed 15 percent of the plan's
2 premium which is based on identifiable dif-
3 ferences in marketing and other legitimate ad-
4 ministrative costs which vary by size of the en-
5 rolling group and method of enrollment, includ-
6 ing enrollment directly through a health plan,
7 an employer, or a broker (as defined in such
8 standards).

9 “(B) APPLICATION.—The administrative
10 charge for any plan described in subparagraph
11 (A) shall be applied uniformly with respect to
12 group size and method of enrollment.

13 “(4) DISCOUNTS.—In accordance with the re-
14 form standards, an insurer may allow premium dis-
15 counts based on health promoting activities.

16 **“SEC. 21115. BENEFITS OFFERED.**

17 “(a) OFFERING OF PACKAGES INCLUDING
18 FEDMED.—Subject to the requirements of section
19 21002(c), a health plan may offer, in addition to a
20 FedMed benefits package, other benefits packages in a
21 community rating area, if the rates for all such packages
22 (including the FedMed) are based on the plan's total en-
23 rollment in the community-rated population in such area
24 and the rating variations do not exceed the difference in

1 the actuarial value of the specific benefit variations for
2 such population.

3 “(b) FEDMED BENEFITS PACKAGE DESCRIBED.—

4 “(1) IN GENERAL.—

5 “(A) PACKAGE DESCRIBED.—A FedMed
6 benefits package described in this subsection is
7 a benefits package that covers all of the items
8 and services under the categories of health care
9 items and services specified by the Secretary
10 under paragraph (2) when medically necessary
11 or appropriate (as determined in accordance
12 with paragraph (3)) and provides for a cost-
13 sharing schedule specified by the Secretary
14 under paragraph (4).

15 “(B) ACTUARIAL VALUE.—

16 “(i) INITIAL PACKAGE.—For 1997,
17 the FedMed benefits package established
18 by the Secretary under this subsection that
19 has the lowest actuarial value of all the
20 FedMed benefits packages established by
21 the Secretary under this subsection, shall
22 have an actuarial value that equals the ac-
23 tual value of the benefits package pro-
24 vided under the health benefits plan of-
25 fered under chapter 89 of title 5, United

1 States Code, during 1994 with the highest
2 enrollment, adjusted for a national popu-
3 lation under 65 years of age (as deter-
4 mined by the Secretary).

5 “(ii) SUCCEEDING YEARS.—For suc-
6 ceeding years, the FedMed benefits pack-
7 age established by the Secretary under this
8 subsection that has the lowest actuarial
9 value of all the FedMed benefits packages
10 established by the Secretary under this
11 subsection for the year, shall have an actu-
12 arial value that equals the actuarial value
13 of the FedMed benefits package that has
14 the lowest actuarial value of all the
15 FedMed benefits packages that existed in
16 the preceding year.

17 “(iii) DETERMINING ACTUARIAL
18 VALUE.—For purposes of clause (ii), the
19 Secretary shall use the same actuarial as-
20 sumptions in determining the actuarial
21 value of the FedMed benefits packages for
22 the current and preceding years.

23 “(2) CATEGORIES OF HEALTH CARE ITEMS AND
24 SERVICES.—

1 “(A) IN GENERAL.—The categories of
2 health care items and services specified by the
3 Secretary under this paragraph shall include at
4 least the categories described in section 1302(1)
5 of the Public Health Service Act and section
6 8904(a) of title 5, United States Code. The
7 Secretary may add or delete categories of health
8 care items and services under this paragraph as
9 medical practice changes.

10 “(B) SPECIFYING ITEMS AND SERVICES.—

11 “(i) IN GENERAL.—The Secretary
12 shall specify the items and services under
13 the categories specified under subpara-
14 graph (A).

15 “(ii) PRIORITIES FOR THE SEC-
16 RETARY.—In specifying items and services
17 under this subparagraph the Secretary
18 shall take into account the following:

19 “(I) MENTAL HEALTH AND SUB-
20 STANCE ABUSE SERVICES.—With re-
21 spect to mental health and substance
22 abuse services, the Secretary shall
23 give priority to—

24 “(aa) parity for such serv-
25 ices with other medical services

1 with respect to cost-sharing and
2 duration of treatment;

3 “(bb) management for such
4 services that ensures access to
5 medically appropriate treatment;
6 and

7 “(cc) encouraging the use of
8 outpatient treatments to the
9 greatest extent feasible.

10 “(II) VULNERABLE POPU-
11 LATIONS AND UNDERSERVED
12 AREAS.—The Secretary shall give pri-
13 ority to the needs of children and vul-
14 nerable populations, including those
15 populations in rural, frontier, and un-
16 derserved areas.

17 “(III) PREVENTION.—The Sec-
18 retary shall give priority to improving
19 the health of individuals through pre-
20 vention.

21 “(3) MEDICAL NECESSITY OR APPROPRIATE-
22 NESS.—

23 “(A) DETERMINATIONS BY HEALTH
24 PLANS.—

1 “(i) IN GENERAL.—The determination
2 of medical necessity or appropriateness of
3 specific treatments or procedures shall be
4 made by individual health plans with ref-
5 erence to criteria established under sub-
6 paragraph (B).

7 “(ii) NEW PROCEDURES AND TECH-
8 NOLOGIES.—Health plans may make cov-
9 erage decisions regarding new procedures
10 and technologies with reference to the cri-
11 teria established by the Secretary under
12 subparagraph (B).

13 “(B) CRITERIA ESTABLISHED.—The Sec-
14 retary shall establish general criteria for deter-
15 mining whether an item or service specified by
16 the Secretary under paragraph (2)(B) is medi-
17 cally necessary or appropriate.

18 “(4) COST-SHARING.—The Secretary shall es-
19 tablish cost-sharing schedules to be provided by a
20 FedMed benefits package. In establishing such cost-
21 sharing schedules, the Secretary shall meet the fol-
22 lowing requirements:

23 “(A) ANNUAL BASIS.—The Secretary shall
24 review and update cost-sharing schedules as de-

1 terminated appropriate by the Secretary, but on
2 at least an annual basis.

3 “(B) DELIVERY SYSTEMS.—

4 “(i) IN GENERAL.—In establishing
5 cost-sharing schedules for FedMed benefits
6 packages, the Secretary shall ensure that
7 the schedules permit a variety of delivery
8 systems, including fee-for-service, preferred
9 provider organizations, point of service,
10 and health maintenance organizations.

11 “(ii) INITIAL COST-SHARING SCHED-
12 ULES.—The cost-sharing schedules initially
13 established by the Secretary shall meet the
14 following requirements:

15 “(I) MODERATE COST-SHAR-
16 ING.—A moderate cost-sharing sched-
17 ule shall be similar to the cost-sharing
18 schedule under the health benefits
19 plan offered under chapter 89 of title
20 5, United States Code, with the high-
21 est enrollment that uses a fee-for-serv-
22 ice delivery system.

23 “(II) LOW COST-SHARING.—A
24 low cost-sharing schedule shall be
25 similar to the cost-sharing schedule

1 under the health benefits plan offered
2 under chapter 89 of title 5, United
3 States Code, with the highest enroll-
4 ment that provides a health mainte-
5 nance organization.

6 “(III) INTERMEDIATE COST-
7 SHARING.—An intermediate cost-shar-
8 ing schedule for a preferred provider
9 system, point of service system, or
10 similar system, shall encourage use of
11 providers in the network by providing
12 for higher cost-sharing for out-of-net-
13 work, non-emergency services.

14 “(C) COST-SHARING RULES.—Cost-sharing
15 schedules established by the Secretary may in-
16 clude copayments, coinsurance, deductibles, and
17 out-of-pocket limits. The copayments, coinsur-
18 ance, deductibles and out-of-pocket limits on
19 cost-sharing for a year under the schedules
20 shall be applied based upon expenses incurred
21 for covered items and services furnished in the
22 year.

23 “(c) LIFETIME LIMITATION PROHIBITED.—No
24 health plan may impose a lifetime limitation on the provi-
25 sion of benefits.

1 **“SEC. 21116. RISK ADJUSTMENT.**

2 “(a) IN GENERAL.—Each community-rated health
3 plan shall participate in a risk adjustment program of the
4 State described in section 21014.

5 “(b) MANDATORY STOP-LOSS INSURANCE.—Each
6 employer which is not an experience-rated employer and
7 which sponsors a self-insured health plan shall carry stop-
8 loss insurance purchased from a reinsurer regulated by the
9 participating State.

10 **“SEC. 21117. PROHIBITION OF DISCRIMINATION.**

11 “(a) IN GENERAL.—No State, health plan, or health
12 plan sponsor may discriminate in participation, reimburse-
13 ment, or indemnification against a health care provider
14 who is acting within the scope of the provider’s license
15 or certification under applicable State or Federal law sole-
16 ly on the basis of such license or certification of such pro-
17 vider.

18 “(b) NUMBER AND TYPE.—Nothing in this title
19 shall—

20 “(1) prevent a health plan from matching the
21 number and type of health care providers to the
22 needs of the plan members; or

23 “(2) except as specifically provided in this title,
24 establish any other measure designed to maintain
25 quality or to control costs.

1 **“PART III—MINIMUM DELIVERY SYSTEM**
2 **GUIDELINES APPLICABLE TO HEALTH PLANS**

3 **“SEC. 21121. MINIMUM DELIVERY SYSTEM GUIDELINES.**

4 “(a) IN GENERAL.—The minimum guidelines for the
5 certification by a participating State of health plan deliv-
6 ery systems specified under this part are as follows:

7 “(1) Establishing and maintaining health plan
8 quality assurance, including—

9 “(A) quality management;

10 “(B) credentialing;

11 “(C) utilization management;

12 “(D) governance;

13 “(E) plan and quality processes;

14 “(F) health care provider selection and due
15 process in selection; and

16 “(G) practice guidelines and protocols.

17 “(2) Providing consumer protection for health
18 plan enrollees, including—

19 “(A) comparative consumer information
20 with respect to health plans in a form specified
21 in subtitle B of title XI;

22 “(B) marketing agents and materials;

23 “(C) nondiscrimination in plan enrollment,
24 disenrollment and service provision;

25 “(D) continuation of treatment with re-
26 spect to health plans that become insolvent;

1 “(E) grievance procedures;

2 “(F) advanced directives; and

3 “(G) financial practices of health plans
4 that interfere with quality of care.

5 “(3) Ensuring reasonable access to health care
6 services, including—

7 “(A) ensuring that vulnerable populations
8 have access to health care services, in accord-
9 ance with the recommendations of the Prospec-
10 tive Payment Assessment Commission under
11 subsection (c);

12 “(B) anti red-lining rules; and

13 “(C) prohibition on plan discrimination
14 against health care providers (including dis-
15 crimination solely on the basis of the academic
16 degree of the provider).

17 “(4) Health plan financial standards, includ-
18 ing—

19 “(A) plan solvency requirements;

20 “(B) financial standards relating to liquid-
21 ity, accounting and reporting; and

22 “(C) guaranty fund participation.

23 “(b) CUSTOMIZED GUIDELINES.—In establishing
24 guidelines under subsection (a), the Secretary shall rec-

1 ommend customized guidelines for the certification of dif-
 2 ferent types of health plans, taking into consideration—

3 “(1) frontier, rural, and inner city factors; and

4 “(2) commercial insurance, managed-care plans,
 5 and delivery-system or provider-based plans.

6 “(c) ACCESS TO VULNERABLE POPULATIONS.—Not
 7 later than 1 year after the date of enactment of this title,
 8 the Prospective Payment Assessment Commission shall
 9 submit recommendations to the Secretary concerning
 10 guidelines under subsection (a)(3)(A). In preparing such
 11 recommendations, the Commission shall consider—

12 “(1) the anticipated impact of health care re-
 13 form on access to health care services by individuals
 14 in vulnerable populations; and

15 “(2) safeguards needed to ensure the continued
 16 access to, and payment for, health care services pro-
 17 vided to individuals in vulnerable populations.

18 **“Subtitle C—Expanded Access to** 19 **Health Plans**

20 **“PART I—ACCESS THROUGH HEALTH INSURANCE** 21 **PURCHASING COOPERATIVES**

22 **“SEC. 21201. ESTABLISHMENT AND ORGANIZATION.**

23 “(a) IN GENERAL.—Individual and small group mar-
 24 ket purchasing cooperatives (in this title referred to as
 25 ‘purchasing cooperatives’) may be established in accord-

1 ance with this part. Each purchasing cooperative shall be
 2 chartered under State law. An insurer may not form, un-
 3 derwrite, or possess a majority vote of a purchasing coop-
 4 erative, but may administer such a cooperative.

5 “(b) DUTIES OF PURCHASING COOPERATIVES.—

6 “(1) IN GENERAL.—Subject to paragraph (2),
 7 each purchasing cooperative shall—

8 “(A) provide access to insured certified
 9 health plans to members throughout the entire
 10 community rating area served by the coopera-
 11 tive;

12 “(B) enter into agreements with insured
 13 certified health plans selected by the coopera-
 14 tive;

15 “(C) enter into agreements with commu-
 16 nity-rated employers located in the community
 17 rating area served by the cooperative;

18 “(D) enroll community-rated individuals in
 19 insured certified health plans; and

20 “(E) collect premiums from individuals en-
 21 rolled in insured certified health plans through
 22 the purchasing cooperative and forward such
 23 premiums to the plans.

24 “(2) LIMITATION ON ACTIVITIES.—A purchas-
 25 ing cooperative shall not—

1 “(A) perform any activity (including re-
2 view, approval, or enforcement) relating to pay-
3 ment rates for providers;

4 “(B) perform any activity (including cer-
5 tification or enforcement) relating to compliance
6 of insured certified health plans with the re-
7 quirements of part I or II of subtitle B; or

8 “(C) assume financial risk in relation to
9 any such plan.

10 “(d) RULES OF CONSTRUCTION.—

11 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-
12 ing in this section shall be construed as requiring—

13 “(A) that a purchasing cooperative be es-
14 tablished in each community rating area; and

15 “(B) that there be only one purchasing co-
16 operative established with respect to a commu-
17 nity rating area.

18 “(2) SINGLE ORGANIZATION SERVING MUL-
19 TIPLE AREAS.—Nothing in this section shall be con-
20 strued as preventing a single entity from being the
21 purchasing cooperative for more than one commu-
22 nity rating area.

1 **“PART II—ACCESS THROUGH FEHBP**

2 **“SEC. 21211. SMALL BUSINESS PARTICIPATION IN FEHBP.**

3 “For access by small businesses to health benefits
4 plans offered by the Federal Employee Health Benefits
5 Program, see chapter 90 of title 5, United States Code.

6 **“PART III—ACCESS THROUGH ASSOCIATION**

7 **PLANS**

8 **“Subpart A—Qualified Association Plans**

9 **“SEC. 21221. TREATMENT OF QUALIFIED ASSOCIATION**
10 **PLANS.**

11 “(a) GENERAL RULE.—For purposes of this title, in
12 the case of a qualified association plan—

13 “(1) except as otherwise provided in this sub-
14 part, the plan shall meet all applicable requirements
15 of this title for certified health plans offered by ex-
16 perience-rated employers,

17 “(2) if such plan is certified as meeting such
18 requirements and the requirements of this subpart,
19 such plan shall be treated as a plan established and
20 maintained by an experience-rated employer which
21 meets the requirements of this title for experience-
22 rated plans, and individuals enrolled in such plan
23 shall be treated as experience-rated individuals, and

24 “(3) any individual who is a member of the as-
25 sociation not enrolling in the plan shall not be treat-

1 ed as an experience-rated individual solely by reason
2 of membership in such association.

3 “(b) ELECTION TO BE TREATED AS PURCHASING
4 COOPERATIVE.—Subsection (a) shall not apply to a quali-
5 fied association plan if—

6 “(1) the health plan sponsor makes an irrev-
7 ocable election to be treated as a purchasing cooper-
8 ative for purposes of this title, and

9 “(2) such sponsor meets all requirements of
10 this title applicable to a purchasing cooperative.

11 **“SEC. 21222. QUALIFIED ASSOCIATION PLAN DEFINED.**

12 “(a) GENERAL RULE.—For purposes of this subpart,
13 a plan is a qualified association plan if the plan is a mul-
14 tiple employer welfare arrangement or similar arrange-
15 ment—

16 “(1) which is maintained by a qualified associa-
17 tion,

18 “(2) which has at least 500 participants in the
19 United States,

20 “(3) under which the benefits provided consist
21 solely of medical care (as defined in section 213(d)
22 of the Internal Revenue Code of 1986),

23 “(4) which may not condition participation in
24 the plan, or terminate coverage under the plan, on
25 the basis of the health status or health claims expe-

1 rience of any employee or member or dependent of
2 either,

3 “(5) which provides for bonding, in accordance
4 with regulations providing rules similar to the rules
5 under section 412 of the Employee Retirement In-
6 come Security Act of 1974, of all persons operating
7 or administering the plan or involved in the financial
8 affairs of the plan, and

9 “(6) which notifies each participant or provider
10 that it is certified as meeting the requirements of
11 this title applicable to it.

12 “(b) SELF-INSURED PLANS.—In the case of a plan
13 which is not fully insured (within the meaning of section
14 514(b)(6)(D) of the Employee Retirement Income Secu-
15 rity Act of 1974), the plan shall be treated as a qualified
16 association plan only if—

17 “(1) the plan meets minimum financial solvency
18 and cash reserve requirements for claims which are
19 established by the Secretary of Labor and which
20 shall be in lieu of any other such requirements under
21 this title,

22 “(2) the plan provides an annual funding report
23 (certified by an independent actuary) and annual fi-
24 nancial statements to the Secretary of Labor and
25 other interested parties, and

1 “(3) the plan appoints a plan sponsor who is
2 responsible for operating the plan and ensuring com-
3 pliance with applicable Federal and State laws.

4 “(c) CERTIFICATION.—

5 “(1) IN GENERAL.—A plan shall not be treated
6 as a qualified association plan for any period unless
7 there is in effect a certification by the Secretary of
8 Labor that the plan meets the requirements of this
9 subpart. For purposes of this title, the Secretary of
10 Labor shall be the appropriate certifying authority
11 with respect to the plan.

12 “(2) FEE.—The Secretary of Labor shall re-
13 quire a \$5,000 fee for the original certification
14 under paragraph (1) and may charge a reasonable
15 annual fee to cover the costs of processing and re-
16 viewing the annual statements of the plan.

17 “(3) EXPEDITED PROCEDURES.—The Secretary
18 of Labor may by regulation provide for expedited
19 registration, certification, and comment procedures.

20 “(4) AGREEMENTS.—The Secretary of Labor
21 may enter into agreements with the States to carry
22 out the Secretary’s responsibilities under this sub-
23 part.

24 “(d) AVAILABILITY.—Notwithstanding any other
25 provision of this title, a qualified association plan may

1 limit coverage to individuals who are members of the
2 qualified association establishing or maintaining the plan,
3 an employee of such member, or a spouse or dependent
4 of either.

5 “(e) SPECIAL RULES FOR EXISTING PLANS.—In the
6 case of a plan in existence on January 1, 1994—

7 “(1) the requirements of subsection (a) (other
8 than paragraph (4), (5), and (6) thereof) shall not
9 apply,

10 “(2) no original certification shall be required
11 under this subpart, and

12 “(3) no annual report or funding statement
13 shall be required before January 1, 1996, but the
14 plan shall file with the Secretary of Labor a descrip-
15 tion of the plan and the name of the plan sponsor.

16 **“SEC. 21223. DEFINITIONS AND SPECIAL RULES.**

17 “(a) QUALIFIED ASSOCIATION.—For purposes of this
18 subpart, the term ‘qualified association’ means any organi-
19 zation which—

20 “(1) is organized and maintained in good faith
21 by a trade association, an industry association, a
22 professional association, a chamber of commerce, a
23 religious organization, a public entity association, or
24 other business association serving a common or simi-
25 lar industry,

1 “(2) is organized and maintained for substan-
2 tial purposes other than to provide a health plan,

3 “(3) has a constitution, bylaws, or other similar
4 governing document which states its purpose, and

5 “(4) receives a substantial portion of its finan-
6 cial support from its active, affiliated, or federation
7 members.

8 “(b) MULTIPLE EMPLOYER WELFARE ARRANGE-
9 MENT.—For purposes of this subchapter, the term ‘mul-
10 tiple employer welfare arrangement’ has the meaning
11 given such term by section 3(40) of the Employee Retire-
12 ment Income Security Act of 1974.

13 “(c) COORDINATION WITH SUBPART B.—The term
14 ‘qualified association plan’ shall not include a plan to
15 which subpart B applies.

16 **“Subpart B—Special Rule for Church,**
17 **Multiemployer, and Cooperative Plans**

18 **“SEC. 21225. SPECIAL RULE FOR CHURCH, MULTIEM-**
19 **PLOYER, AND COOPERATIVE PLANS.**

20 “(a) GENERAL RULE.—For purposes of this title, in
21 the case of a health plan to which this section applies—

22 “(1) except as otherwise provided in this sub-
23 part, the plan shall be required to meet all applicable
24 requirements of this title for certified health plans
25 offered by experience-rated employers,

1 “(3) if such plan is certified as meeting such
2 requirements, such plan shall be treated as a plan
3 established and maintained by an experience-rated
4 employer which meets the requirements of this title
5 for experience-rated plans, and individuals enrolled
6 in such plan shall be treated as experience-rated in-
7 dividuals, and

8 “(3) any individual eligible to enroll in the plan
9 who does not enroll in the plan shall not be treated
10 as an experience-rated individual solely by reason of
11 being eligible to enroll in the plan.

12 “(b) MODIFIED STANDARDS.—

13 “(1) CERTIFYING AUTHORITY.—For purposes
14 of this title, the Secretary of Labor shall be the ap-
15 propriate certifying authority with respect to a plan
16 to which this section applies.

17 “(2) AVAILABILITY.—Rules similar to the rules
18 of subsection (d) of section 21222 shall apply to a
19 plan to which this section applies.

20 “(3) ACCESS.—An employer which, pursuant to
21 a collective bargaining agreement, offers an em-
22 ployee the opportunity to enroll in a plan described
23 in subsection (c)(2) shall not be required to make
24 any other plan available to the employee.

1 “(4) TREATMENT UNDER STATE LAWS.—A
2 church plan described in subsection (c)(1) which is
3 certified as meeting the requirements of this section
4 shall not be deemed to be a multiple employer wel-
5 fare arrangement or an insurance company or other
6 insurer, or to be engaged in the business of insur-
7 ance, for purposes of any State law purporting to
8 regulate insurance companies or insurance contracts.

9 “(c) PLANS TO WHICH SECTION APPLIES.—This sec-
10 tion shall apply to a health plan which—

11 “(1) is a church plan (as defined in section
12 414(e) of the Internal Revenue Code of 1986) which
13 has at least 100 participants in the United States,

14 “(2) is a multiemployer plan (as defined in sec-
15 tion 3(37) of the Employee Retirement Income Se-
16 curity Act of 1974) which is maintained by a health
17 plan sponsor described in section 3(16)(B)(iii) of
18 such Act and which has at least 500 participants in
19 the United States, or

20 “(3) is a plan which is maintained by a rural
21 electric cooperative or a rural telephone cooperative
22 association (within the meaning of section 3(40) of
23 such Act and which has at least 500 participants in
24 the United States.

1 **“PART IV—ACCESS THROUGH EMPLOYERS**

2 **“SEC. 21231. GENERAL EMPLOYER RESPONSIBILITIES.**

3 “(a) PAYROLL DEDUCTION.—

4 “(1) IN GENERAL.—If—

5 “(A) a certified health plan, or purchasing
6 cooperative on behalf of such a plan, requests
7 an employer under this section to withhold pre-
8 miums with respect to any employee enrolled in
9 the plan, or

10 “(B) an employee requests an employer to
11 withhold premiums to a certified health plan in
12 which the employee is enrolled or enrolling,
13 the employer shall deduct and withhold such pre-
14 miums (less any employer contribution) through
15 payroll deduction and pay the amounts deducted and
16 withheld to the plan or to the purchasing coopera-
17 tive.

18 “(2) PAYROLL DEDUCTIONS.—

19 “(A) FREQUENCY.—In the case of an em-
20 ployee who is paid wages or other compensa-
21 tion—

22 “(i) on a monthly or more frequent
23 basis, the employer shall deduct and with-
24 hold, and pay, such premiums at the same
25 time as the payment of such wages or
26 other compensation, or

1 “(ii) less frequently than monthly, the
2 employer shall pay such premiums on a
3 monthly basis.

4 “(B) EMPLOYEE PROTECTIONS.—

5 “(i) WITHHOLDING CONSTITUTES
6 SATISFACTION OF OBLIGATION.—If an em-
7 ployee notifies the health plan sponsor that
8 the employee has requested the employer
9 withholding of a certain amount, the with-
10 holding of such an amount by the employer
11 under subparagraph (A) shall constitute
12 satisfaction of the employee’s obligation to
13 pay the health plan with respect to such
14 amount.

15 “(ii) DIRECT PAYMENT ALLOWED IN
16 CASE OF NONPAYMENT.—In the case of
17 the nonpayment to a health plan of any
18 amount withheld by an employer, the plan
19 shall notify such employee of such
20 nonpayment and shall allow the employee
21 to make direct payments to the plan effec-
22 tive with the next succeeding payment pe-
23 riod.

24 “(b) TIME PERIOD FOR EMPLOYERS.—An employer
25 shall meet the requirements of this section with respect

1 to any new employee within the 30-day period beginning
2 on the date of hire.

3 **“SEC. 21232. DEVELOPMENT OF LARGE EMPLOYER PUR-**
4 **CHASING GROUPS.**

5 “Nothing in this title shall be construed as prohibit-
6 ing 2 or more experience-rated employers from joining to-
7 gether to purchase insurance for their employees, except
8 that each such employer shall be responsible for meeting
9 the employer’s requirements under this title with respect
10 to its employees.

11 **“SEC. 21233. REPORT TO EMPLOYEES ON EMPLOYER**
12 **HEALTH CARE CONTRIBUTIONS.**

13 “Each employer with more than 25 full-time employ-
14 ees shall report each year to each full-time employee the
15 amount of the employer contributions made on behalf of
16 the employee for health insurance coverage. An employer
17 may use any reasonable means to carry out its responsibil-
18 ities under this section (including the calculation of the
19 amount of the employer contribution).

20 **“SEC. 21234. EMPLOYER MAY NOT DISCRIMINATE AGAINST**
21 **SUBSIDY ELIGIBLE INDIVIDUALS.**

22 “(a) GENERAL RULE.—Any employer which elects to
23 make employer contributions on behalf of its employees
24 for health insurance coverage shall not condition, or vary,
25 such contributions with respect to any employee by reason

1 of such employee's status as an individual eligible for pre-
 2 mium assistance under subtitle B of title I of the Ameri-
 3 ca's Health Care Option Act.

4 “(b) ELIMINATION OF CONTRIBUTIONS.—An em-
 5 ployer shall not be treated as failing to meet the require-
 6 ments of subsection (a) if the employer ceases to make
 7 employer contributions for health insurance coverage for
 8 all its employees.

9 **“SEC. 21235. ENFORCEMENT.**

10 “A State program shall provide for the monitoring
 11 and enforcement of the requirements of this part.”.

12 **Subtitle B—Consolidation of** 13 **Federal Research**

14 **SEC. 211. CONSOLIDATION OF FEDERAL RESEARCH.**

15 (a) AGENCY FOR QUALITY ASSURANCE AND
 16 CONSUMER INFORMATION.—

17 (1) IN GENERAL.—There is established within
 18 the Department of Health and Human Services an
 19 agency to be known as the Agency for Quality As-
 20 surance and Consumer Information (hereafter re-
 21 ferred to in this section as the “Agency”).

22 (2) PURPOSE.—The purpose of the Agency is to
 23 act as the center for all Federal research activities
 24 relating to quality and consumer information in
 25 health care.

1 (3) ADMINISTRATOR.—There shall be at the
2 head of the Agency an official to be known as the
3 Administrator for Quality Assurance and Consumer
4 Information (hereafter referred to in this section as
5 the “Administrator”). The Administrator shall be
6 appointed by the Secretary of Health and Human
7 Services (hereafter referred to in this section as the
8 “Secretary”).

9 (b) CONSOLIDATION.—

10 (1) ACTION BY SECRETARY.— The Secretary,
11 acting through the Administrator, shall consolidate
12 Federal research activities relating to quality and
13 consumer information in health care through the
14 Agency to enable States to gain access to the results
15 of such research from a central source.

16 (2) ACTION BY ADMINISTRATOR.—The Admin-
17 istrator shall assume the following responsibilities:

18 (A) Responsibilities of the Administrator
19 for Health Care Policy and Research under title
20 IX of the Public Health Service Act and under
21 section 1142 of the Social Security Act.

22 (B) Responsibilities of the Director of the
23 National Center for Health Statistics under sec-
24 tion 306 of the Public Health Service Act.

1 (C) Responsibilities of the Director of the
2 Office of Medical Applications of Research at
3 the National Institutes of Health.

4 (D) Responsibilities of the Director of the
5 Office of Research and Demonstrations of the
6 Health Care Financing Administration, to the
7 extent such responsibilities relate to clinical
8 evaluations.

9 (c) DUTIES.—

10 (1) IN GENERAL.—In carrying out subsection
11 (b)(1), the Secretary, acting through the Adminis-
12 trator, shall conduct and support research, dem-
13 onstration projects, evaluations, training, guideline
14 development, and the dissemination of information,
15 on measures and standards of quality and consumer
16 information relating to health care services and on
17 systems for the delivery of such services. Activities
18 under this section shall include—

19 (A) research with respect to the effective-
20 ness and appropriateness of health care services
21 and procedures;

22 (B) research with respect to quality man-
23 agement and improvement efforts of health care
24 systems;

1 (C) the conduct of consumer information
2 and surveys concerning—

- 3 (i) access to care;
4 (ii) use of health services;
5 (iii) health outcomes; and
6 (iv) patient satisfaction;

7 (D) the development, dissemination, appli-
8 cation, and evaluation of practice guidelines;

9 (E) the conduct, in partnership with ex-
10 perts, of information effectiveness trials in the
11 private sector; and

12 (F) the systematic evaluation of existing
13 and new treatments and diagnostic technologies
14 in an effort to improve the knowledge base to
15 assist in clinical decision-making and policy
16 choices.

17 (2) EXPERTS.—The Secretary, acting through
18 the Administrator, shall carry out the activities de-
19 scribed in paragraph (1) in consultation with private
20 and public experts in quality and consumer informa-
21 tion.

22 (3) GUIDELINES.—The Administrator shall de-
23 velop and recommend to the Secretary minimum
24 guidelines for health care quality measures,
25 consumer information categories, and access to

1 health services. Such guidelines shall be utilized by
2 the Secretary in establishing guidelines for certifi-
3 cation under part III of subtitle B of title XXI of
4 the Social Security Act.

5 (4) DATA.—The Administrator shall rec-
6 ommend to the Secretary standards and procedures
7 for the administration of data and transactions re-
8 lating to health care quality, consumer information,
9 access, and effectiveness under subtitle B of title XI
10 of the Social Security Act.

11 (5) RESEARCH.—The Agency shall be respon-
12 sible for oversight with respect to basic and applied
13 research concerning the matters described in para-
14 graph (1).

15 (d) TRANSFERS.—There are hereby transferred to
16 the Agency the staff, funds, and other assets of the agen-
17 cies for which the Agency is assuming responsibilities
18 under subsection (b)(2).

19 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
20 purpose of carrying out this section, there are authorized
21 to be appropriated \$100,000,000 for fiscal year 1996,
22 \$150,000,000 for fiscal year 1997, \$200,000,000 for each
23 of the fiscal years 1998 and 1999, and \$250,000,000 for
24 fiscal year 2000. Beginning with fiscal year 1997, at least
25 one-third of the funds for each year shall be used for im-

1 plementing the results of quality and consumer informa-
 2 tion research, such as grants to entities to test the use
 3 of practice guidelines in the health care delivery system.

4 **Subtitle C—Self-Employed Individ-**
 5 **ual and Small Employer Particip-**
 6 **ation in Federal Employees**
 7 **Health Benefits Plans**

8 **SEC. 221. SELF-EMPLOYED INDIVIDUAL AND SMALL EM-**
 9 **PLOYER PARTICIPATION IN FEDERAL EM-**
 10 **PLOYEES HEALTH BENEFITS PLANS.**

11 Part III of title 5, United States Code, is amended
 12 by inserting after chapter 89 the following new chapter:

13 **“CHAPTER 90—SMALL BUSINESS PARTICI-**
 14 **PATION IN FEDERAL EMPLOYEE**
 15 **HEALTH BENEFITS PLANS**

“Sec.

“9001. Definition.

“9002. Application to small business participants.

“9003. Small business participation.

“9004. Contributions.

“9005. Continued coverage.

“9006. Schedule of small business participation.

“9007. Cost comparison reports and reductions.

16 **“§ 9001. Definition**

17 “(a) For purposes of this chapter, the term ‘small
 18 business’ means any business entity which employs 50 or
 19 less employees (including businesses with one self-em-
 20 ployed individual).

1 “(b) For purposes of subsection (a), the rules under
2 section 52 of the Internal Revenue Code of 1986 shall
3 apply.

4 “(c) No entity, the sole purpose of which is to provide
5 health care coverage for its members, shall be considered
6 a small business for purposes of this chapter.

7 **“§ 9002. Application to small business participants**

8 “(a) The Office of Personnel Management shall pro-
9 mulgate regulations to apply the provisions of chapter 89,
10 relating to health benefits plans, to the greatest extent
11 practicable to small businesses and individuals covered
12 under the provisions of this chapter.

13 “(b) Notwithstanding the provisions of subsection
14 (a), carriers shall offer the same health benefits plans for
15 the same premiums as are offered under chapter 89.

16 “(c) Notwithstanding the provisions of subsection (a),
17 the provisions of section 8907 shall not apply to individ-
18 uals covered under this chapter, except the Office of Per-
19 sonnel Management shall establish a method to dissemi-
20 nate information relating to health benefits plans (includ-
21 ing information concerning periods of open enrollment and
22 a summary of the information described in section 8908)
23 to such individuals through small business participants
24 and carriers.

1 “(d)(1) A carrier offering a health benefits plan
2 under this chapter may charge a fee to participating small
3 businesses for the administrative expenses related to the
4 enrollment of such businesses in such plan, not to exceed
5 the lesser of—

6 “(A) 15 percent of the premiums charged each
7 such business, or

8 “(B) the amount charged each such business of
9 the same size.

10 “(2) A carrier shall consult with the Office of Person-
11 nel Management before setting or adjusting any fee under
12 this subsection.

13 “(e) A carrier offering a health benefits plan under
14 this chapter may impose group participation requirements
15 if such requirements are standard for all groups.

16 **“§ 9003. Small business participation**

17 “Any small business which desires to participate in
18 a health benefits plan under this chapter may enter into
19 a contract with a carrier in accordance with this chapter.
20 Such contract shall provide for—

21 “(1) a term of no less than 1 year, and

22 “(2) early termination for nonpayment of pre-
23 miums.

1 **“§ 9004. Contributions**

2 “(a) Subject to the provisions of subsection (b), an
3 individual enrolled in a health benefits plan under this
4 chapter shall make contributions equal to the amount of
5 contributions made by—

6 “(1) a Federal enrollee in such plan under indi-
7 vidual, or self and family coverage, as the case may
8 be, as determined under section 8906;

9 “(2) the Federal agency making Government
10 contributions determined under section 8906 for
11 such Federal enrollee; and

12 “(3) the administrative charge applied by the
13 carrier under section 9002(d).

14 “(b)(1) A small business may by contract agree to
15 make any amount of the contribution required under sub-
16 section (a) on behalf of an enrollee under such subsection.

17 “(2) An agency of a State government may provide
18 any amount of the contribution required under subsection
19 (a) on behalf of an enrollee under such subsection.

20 “(c) A small business participating under this chap-
21 ter shall—

22 “(1) collect contributions from employees by
23 withholdings from pay or by another method or
24 schedule;

25 “(2) make payments of such contributions to
26 the contracted carrier;

1 “(3) maintain and make available such records
2 as the Office, applicable State insurance authority,
3 or carrier may require; and

4 “(4) provide any other related administrative
5 service in carrying out the provisions of this chapter.

6 **“§ 9005. Continued coverage**

7 “(a) Subject to subsection (b), the provisions of sec-
8 tion 8905a shall be made applicable to enrollees and indi-
9 viduals covered by such enrollments under this chapter
10 through section 9002 and the carrier contract entered into
11 under section 9003, except the enrollee shall pay all con-
12 tributions for continued coverage and the applicable
13 amount for administrative expenses unless the applicable
14 small business by contract agrees to pay any part of such
15 contributions or expenses.

16 “(b) An individual may be covered under continued
17 coverage as provided under subsection (a), only if such in-
18 dividual—

19 “(1) was covered by a health benefits plan
20 under this chapter for the 2-year period immediately
21 preceding the date on which continued coverage
22 under this section begins; and

23 “(2) remains in the same plan during the pe-
24 riod of continued coverage as such individual was

1 enrolled in immediately before such period of contin-
2 ued coverage.”.

3 **“§ 9006. Schedule of small business participation**

4 “(a) Subject to the succeeding subsections of this sec-
5 tion, each carrier enrolling individuals of small business
6 participants under this chapter shall ensure that—

7 “(1) in the first contract year in which such
8 carrier covers individuals of small business partici-
9 pants, the number of enrollees from small businesses
10 as provided under this chapter shall be no less than
11 5 percent of the number of Federal enrollees en-
12 rolled by such carrier under chapter 89; and

13 “(2) in the second such year, the number of
14 small business enrollees shall be no less than 10 per-
15 cent of the number of such Federal enrollees;

16 “(3) in the third such year, the number of
17 small business enrollees shall be no less than 10 per-
18 cent of the number of such Federal enrollees; and

19 “(4) in the fourth such year, the number of
20 small business enrollees shall be no less than 10 per-
21 cent of the number of such Federal enrollees.

22 “(b)(1) In the contract year described under sub-
23 section (a)(1), a small business may participate if such
24 business has between 5 and 50 employees.

1 “(2) In the contract year described under subsection
2 (a)(2) small businesses with between 2 and 50 employees
3 may additionally participate.

4 “(3) In the contract year described under subsection
5 (a)(3) and each year thereafter, all small businesses may
6 participate.

7 “(c) If during any contract year described under sub-
8 section (a) (1) through (4), more small businesses apply
9 for participation than are required to participate under
10 such subsection, the carrier shall ensure that a small busi-
11 ness shall have a priority for selection for participation
12 if such business is not offering any type of health insur-
13 ance benefits to its employees.

14 “(d)(1) If a carrier that enrolls individuals of small
15 business participants under this chapter, ceases to offer
16 enrollment to individuals under this chapter in any con-
17 tract year, such carrier may not offer enrollment under
18 this chapter for the following 2 contract years.

19 “(2) The provisions of paragraph (1) shall not be con-
20 strued to require any carrier to terminate health coverage
21 of any individual who is enrolled under this chapter at the
22 time such carrier ceases to offer new enrollments under
23 this chapter.

24 “(e) A small business may participate in a health ben-
25 efits plan as provided under this section if such business

1 meets all such requirements otherwise provided under this
2 chapter.

3 “(f) The Office may waive the requirements under
4 subsection (a), in whole or in part, after making a deter-
5 mination that—

6 “(1) there is insufficient interest in small busi-
7 nesses within the region in participating under this
8 chapter; or

9 “(2) a requirement is beyond the capacity of a
10 carrier to enroll individuals under this chapter.

11 **“§ 9007. Cost comparison reports and reductions**

12 “(a) No later than July 1 of the first contract year
13 implementing health care coverage under this chapter, and
14 on July 1 of each year thereafter, each carrier contracting
15 under chapter 89 or this chapter shall submit a report
16 to the Office of Personnel Management that compares the
17 aggregate cost experiences with respect to coverage be-
18 tween—

19 “(1) Federal employees and other individuals
20 covered under chapter 89; and

21 “(2) individuals covered under this chapter.

22 “(b) Based on the reports submitted under subsection
23 (a), the Office may reduce the percentage requirements
24 under section 9006(a) for any contract year (but not below
25 the percentage of the preceding contract year).”.

1 **SEC. 222. PROHIBITION OF HEALTH BENEFITS PLANS EX-**
2 **CLUSIVELY FOR MEMBERS AND EMPLOYEES**
3 **OF CONGRESS.**

4 No health benefits plan under chapter 89 or 90 of
5 title 5, United States Code, may be offered exclusively
6 to—

7 (1) Members of Congress (including members of
8 family);

9 (2) congressional employees as defined under
10 section 2107 of such title (including members of
11 family); or

12 (3) individuals described under paragraphs (1)
13 and (2).

14 **SEC. 223. STUDY REGARDING NONWORKER AND**
15 **NONCOVERED EMPLOYEE BUY-INS.**

16 The Secretary of Health and Human Services shall
17 study by what method nonworkers and employees of em-
18 ployers not covered under chapter 90 of title 5, United
19 States Code (as added by section 221 of this Act), may
20 be incorporated into the buy-in for coverage under the
21 Federal Employees Health Benefits Plan. The Secretary
22 shall report the results of such study and any appropriate
23 legislative recommendations to the Congress not later than
24 2 years after the date of the enactment of this Act.

1 **SEC. 224. EFFECTIVE DATE.**

2 (a) IN GENERAL.—Except as provided under sub-
3 section (b), the provisions of this subtitle and the amend-
4 ments made by this subtitle shall be effective on and after
5 the first January 1 occurring after the date of the enact-
6 ment of this Act.

7 (b) EXCEPTION.—The provisions of chapters 89 and
8 90 of title 5, United States Code, as amended and effected
9 by this subtitle, relating to the establishment of or exercise
10 of authority (including the promulgation of regulations)
11 by the Office of Personnel Management, the Secretary of
12 Health and Human Services, the President, or any other
13 applicable Federal officer shall take effect on the date of
14 the enactment of this Act in order to establish health bene-
15 fits plans and fully implement the provisions and amend-
16 ments made by this Act no later than the first January
17 1 occurring after the date of the enactment of this Act.

18 **Subtitle D—Report on Health Care**
19 **System**

20 **SEC. 231. REPORT ON HEALTH CARE SYSTEM.**

21 (a) REPORT.—Not later than July 1, 1998, the Presi-
22 dent shall submit to the Congress findings and rec-
23 ommendations (if any) on each of the items described in
24 subsection (b).

25 (b) ITEMS TO BE STUDIED.—The items referred to
26 in subsection (a) are as follows:

1 (1) The characteristics of the insured and unin-
2 sured, including demographic characteristics, work-
3 ing status, health status, and geographic distribu-
4 tion.

5 (2) Methods to improve access to health care
6 and to increase health insurance coverage of the
7 chronically uninsured.

8 (3) The effectiveness of the insurance reforms
9 under subtitle A on access to health care and the
10 costs of health care.

11 (4) The effectiveness of Federal efforts to as-
12 sess the impact of new technology on the cost and
13 availability of new products.

14 (5) The effectiveness of Federal, State, and pri-
15 vate cost containment strategies.

16 (6) The effectiveness of Federal, State, and pri-
17 vate efforts to measure and improve health care out-
18 comes.

19 (7) The effectiveness of the new Federal sub-
20 sidy programs, including recommendations to re-
21 strain future growth.

22 (8) The effectiveness of initiatives targeted to
23 underserved urban and rural populations.

1 **TITLE III—SPECIAL ASSISTANCE**
2 **FOR RURAL, FRONTIER AND**
3 **UNDERSERVED URBAN AREAS**

4 **SEC. 301. PURPOSE.**

5 It is the purpose of this title to—

6 (1) establish safeguards to assist vulnerable
7 populations in accessing local health services and
8 practitioners;

9 (2) provide funding to certain areas to assist
10 health care providers and health plans in such areas
11 in reconfiguring services and establishing networks
12 and health plans to effectively compete in the chang-
13 ing market;

14 (3) provide funding to increase primary care ca-
15 pacity in underserved areas; and

16 (4) provide more flexibility in Medicare rules
17 for health care providers in underserved areas.

18 **SEC. 302. DESIGNATED UNDERSERVED AREAS.**

19 (a) STATE DESIGNATION.—A State may designate
20 certain rural, frontier or urban areas within the State as
21 underserved areas based on—

22 (1) the lack of access to health plans in such
23 areas; and

24 (2) the lack of access to quality health care pro-
25 viders and health care facilities in such areas.

1 (b) ESTABLISHMENT OF PROCEDURE.—

2 (1) IN GENERAL.—The Secretary shall establish
3 a procedure under which the Secretary, upon the re-
4 quest of a State, may certify areas designated by the
5 State under subsection (a) as underserved areas.

6 (2) NONAPPLICABILITY OF OTHER REQUIRE-
7 MENTS.—The Secretary may certify a designated
8 area under paragraph (1) whether or not such area
9 meets the requirements for being considered a medi-
10 cally underserved area or a health professional
11 shortage area.

12 (c) EFFECT OF CERTIFICATION.—Except with re-
13 spect to provisions in this title that explicitly direct assist-
14 ance to those areas currently designated as underserved,
15 in awarding grants, contracts, loans, waivers, or any other
16 assistance under this title (or an amendment made by this
17 title) the Secretary shall give priority to applicants that
18 serve areas certified as underserved areas under sub-
19 section (b).

20 (d) LIMITATION AND REVOCATION.—A certification
21 provided under subsection (b) shall be valid for not more
22 than 3 years. Such a certification may be revoked by the
23 Secretary if the Secretary determines that the criteria de-
24 scribed in paragraphs (1) and (2) of subsection (a) no
25 longer support a certification under this section.

**Subtitle A—Planning,
Demonstrations, and Grants**

**SEC. 311. DEMONSTRATION WAIVERS FOR THE DEVELOP-
MENT OF HEALTH NETWORKS.**

(a) WAIVERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary may conduct a demonstration project under which public or private entities may apply for waivers of any of the provisions of title XVIII and XIX of the Social Security Act in order to operate health networks (as defined in subsection (c)(1)) which—

(i) improve the access of medicare beneficiaries (as defined in subsection (c)(2)) and medicaid beneficiaries (as defined in subsection (c)(3)) to health care services;

(ii) improve the quality of health care services furnished to such beneficiaries;

(iii) improve the outcomes of health care services furnished to such beneficiaries; and

(iv) provide an incentive to private entities to establish networks in areas cer-

1 tified as underserved areas under section
2 302.

3 (B) NUMBER OF WAIVERS.—The Secretary
4 may grant waivers to operate health networks
5 under the demonstration project conducted
6 under this section to a number of public or pri-
7 vate entities determined appropriate by the Sec-
8 retary.

9 (2) APPLICATIONS.—

10 (A) IN GENERAL.—In order to participate
11 in the demonstration project conducted under
12 this subsection, a public or private entity desir-
13 ing to operate a health network shall submit an
14 application to the Secretary which meets the re-
15 quirements of subparagraph (B). Such applica-
16 tion shall be submitted in such manner and at
17 such time as the Secretary shall require.

18 (B) REQUIREMENTS.—An application sub-
19 mitted by a public or private entity under this
20 subsection must provide—

21 (i) a description of the health care
22 providers participating in the health net-
23 work;

24 (ii) a description of the geographic
25 area served by the health networks;

1 (iii) information demonstrating that
2 the private entity has consulted with inter-
3 ested parties with respect to the operation
4 of the health network, including local gov-
5 ernment entities and community groups;

6 (iv) a description of the operational
7 structure of the health network, including
8 whether the network is a managed care en-
9 tity or a fee-for-service provider;

10 (v) a proposal for how payments
11 should be made to the health network
12 under titles XVIII and XIX of the Social
13 Security Act, including a statement as to
14 whether such payments should be made
15 pursuant to the provisions of such titles or
16 pursuant to an alternative payment meth-
17 odology described in the application;

18 (vi) assurances that medicare bene-
19 ficiaries served by the health network will
20 receive care and services of the same qual-
21 ity as the care and services received by
22 other beneficiaries under title XVIII of the
23 Social Security Act;

24 (vii) assurances that medicaid bene-
25 ficiaries served by the health network will

1 receive care and services of the same qual-
2 ity as the care and services received by
3 other beneficiaries under title XIX of the
4 Social Security Act;

5 (viii) a description of how the health
6 network plans to handle any situation in
7 which a medicare beneficiary or medicaid
8 beneficiary served by the network receives
9 health care services from providers outside
10 the network;

11 (ix) assurances that the health net-
12 work is furnishing health care services to a
13 significant number of individuals who are
14 not receiving benefits under titles XVIII
15 and XIX of the Social Security Act;

16 (x) assurances that through sharing
17 of facilities, land, and equipment, the
18 health network will result in a reduction of
19 total capital costs for the area served by
20 the network;

21 (xi) a plan for cooperation in service
22 delivery by health care providers partici-
23 pating in the health network that dem-
24 onstrates the elimination of unnecessary
25 duplication and, when appropriate, the

1 consolidation of specialized services within
2 the area served by the network;

3 (xii) evidence that the health network
4 furnishes services which address the special
5 access needs of the medicare beneficiaries
6 and medicaid beneficiaries served by the
7 network;

8 (xiii) evidence of capability and exper-
9 tise in network planning and management;
10 and

11 (xiv) such additional information as
12 the Secretary determines appropriate.

13 (C) APPROVAL OF APPLICATION.—

14 (i) INITIAL REVIEW.—Within 60 days
15 after an application is submitted by an en-
16 tity under this subsection, the Secretary
17 shall review and approve such application
18 or provide the entity with a list of the
19 modifications that are necessary for such
20 application to be approved.

21 (ii) ADDITIONAL REVIEW.—Within 60
22 days after an entity resubmits any applica-
23 tion under this subsection, the Secretary
24 shall review and approve such application
25 or provide the entity with a summary of

1 which items included on the list provided
2 to the State under clause (i) remain
3 unsatisfied. An entity may resubmit an ap-
4 plication under this subparagraph as many
5 times as necessary to gain approval.

6 (3) COORDINATION WITH OTHER PROGRAMS.—

7 The Secretary shall coordinate the demonstration
8 project conducted under this subsection with any
9 other relevant Federal or State programs in order to
10 prevent duplication and improve the quality and de-
11 livery of health care services to medicare bene-
12 ficiaries and medicaid beneficiaries.

13 (4) PAYMENTS TO NETWORKS.—

14 (A) IN GENERAL.—The Secretary shall de-
15 termine the amount of payments to be made
16 under titles XVIII and XIX to a health network
17 participating in a demonstration project under
18 this subsection based on historic costs adjusted
19 based on population and geographic area as the
20 Secretary determines appropriate to take into
21 account the costs of furnishing health care serv-
22 ices in the area served by the network.

23 (B) BUDGET NEUTRALITY.—The Secretary
24 shall provide that in carrying out the dem-
25 onstration project under this section, the aggre-

1 gate payments under titles XVIII and XIX of
2 the Social Security Act to providers participat-
3 ing in a health network shall be no greater or
4 lesser than what such payments would have
5 been if such providers were not participating in
6 such network.

7 (5) DURATION OF WAIVERS.—Any waiver
8 granted under the demonstration project conducted
9 under this subsection shall be granted for a period
10 determined appropriate by the Secretary. The Sec-
11 retary may terminate such a waiver at any time if
12 the Secretary determines that the health network
13 has failed to furnish health care services in accord-
14 ance with the terms of the waiver.

15 (6) REPORTS.—

16 (A) IN GENERAL.—Each entity receiving a
17 waiver to operate a health network under the
18 demonstration project conducted under this
19 subsection shall, through an independent entity,
20 evaluate the network and submit interim and
21 final reports to the Secretary at such times and
22 containing such information as the Secretary
23 shall require.

24 (B) REPORT TO CONGRESS.—Not later
25 than 60 days after the receipt of a final report

1 by a health network under subparagraph (A)
2 the Secretary shall submit a report to Congress.

3 (b) DEVELOPMENTAL GRANTS.—

4 (1) IN GENERAL.—The Secretary shall award
5 grants to entities which have received a waiver under
6 the demonstration project conducted under sub-
7 section (a) for the purpose of planning and develop-
8 ing health networks.

9 (2) APPLICATION PROCESS.—

10 (A) SUBMISSION OF APPLICATION.—Each
11 entity desiring to receive a grant under this
12 subsection shall submit an application to the
13 Secretary at such time and containing such in-
14 formation as the Secretary determines appro-
15 priate.

16 (B) CONSIDERATION OF APPLICATIONS.—
17 The Secretary shall develop a system for deter-
18 mining the priority for distributing grants
19 under this subsection and such grants shall be
20 distributed in accordance with such system.

21 (3) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated such sums
23 as may be necessary for the purposes of awarding
24 grants under this subsection.

25 (c) DEFINITIONS.—For purposes of this section:

1 (1) FRONTIER AREA.—The term “frontier
2 area” means an area in which 6 or fewer individuals
3 reside per square mile.

4 (2) HEALTH NETWORK.—The term “health net-
5 work” means a formal cooperative arrangement be-
6 tween participating hospitals, physicians, and other
7 health care providers which—

8 (A) furnishes health care services to mem-
9 bers of the community, including medicare
10 beneficiaries and medicaid beneficiaries;

11 (B) is located in a rural, frontier or under-
12 served urban area; and

13 (C) is governed by a board of directors se-
14 lected by participating health care providers.

15 (3) MEDICAID BENEFICIARY.—The term “med-
16 icaid beneficiary” means an individual receiving ben-
17 efits under this XIX of the Social Security Act who
18 resides in a rural, frontier or underserved urban
19 area or who receives health care services from a
20 health care provider located in a rural, frontier or
21 underserved urban area.

22 (4) MEDICARE BENEFICIARY.—The term “med-
23 icare beneficiary” means an individual receiving ben-
24 efits under title XVIII of the Social Security Act
25 who resides in a rural, frontier or underserved urban

1 area or who receives health care services from a
 2 health care provider located in a rural, frontier or
 3 underserved urban area.

4 (5) RURAL AREA.—The term “rural area”
 5 means a rural area as described in section
 6 1886(d)(2)(D) of the Social Security Act.

7 (6) UNDERSERVED URBAN AREA.—The term
 8 “underserved urban area” means an area (other
 9 than a rural area) determined to be underserved by
 10 the Secretary.

11 **SEC. 312. GRANTS FOR THE PLANNING OF HEALTH NET-**
 12 **WORKS OR HEALTH PLANS.**

13 Title XX of the Social Security Act (42 U.S.C. 1397
 14 et seq.) is amended—

15 (1) in the title heading, by adding at the end
 16 thereof the following: “AND MISCELLANEOUS
 17 PROVISIONS”;

18 (2) by inserting after the title heading the fol-
 19 lowing:

20 **“Subtitle A—Block Grants”; and**

21 (3) by adding at the end thereof the following:

1 **“Subtitle B—Health Plans and Net-**
2 **works Initiated by Private Enti-**
3 **ties**

4 “GRANTS FOR THE PLANNING OF HEALTH NETWORKS
5 AND HEALTH PLANS

6 “SEC. 2011. (a) IN GENERAL.—The Secretary shall
7 award grants to private entities submitting applications
8 that are approved under subsection (b) for the purpose
9 of planning and developing health networks or health
10 plans to serve underserved areas certified under section
11 302 of the America’s Health Care Option Act.

12 “(b) APPLICATION PROCESS.—

13 “(1) SUBMISSION OF APPLICATION.—Each pri-
14 vate entity desiring to receive a grant under this sec-
15 tion shall submit an application to the Secretary at
16 such time and containing such information as the
17 Secretary determines appropriate, including—

18 “(A) a description of the health care pro-
19 viders that will participate in the health net-
20 work or serve through the health plan;

21 “(B) a description of the geographic area
22 to be served by the health network or plan;

23 “(C) information demonstrating that the
24 private entity has consulted with interested par-
25 ties with respect to the operation of the health

1 network or plan, including local government en-
2 tities and community groups;

3 “(D) a description of the operational struc-
4 ture of the health network or plan, including
5 whether the network is a managed care entity
6 or a fee-for-service provider;

7 “(E) assurances that through sharing of
8 facilities, land, and equipment, the health net-
9 work will result in a reduction of total capital
10 costs for the area served by the network;

11 “(F) a plan for cooperation in service de-
12 livery by health care providers participating in
13 the health network or plan that demonstrates
14 the elimination of unnecessary duplication and,
15 when appropriate, the consolidation of special-
16 ized services within the area served by the net-
17 work or plan;

18 “(G) evidence that the health network will
19 furnish services which address the special ac-
20 cess needs of the individuals served by the net-
21 work;

22 “(H) a demonstration that the health plan
23 developed will improve access to services for the
24 community served; and

1 “(I) evidence of capability and expertise in
 2 network planning, health plans and manage-
 3 ment.

4 “(2) CONSIDERATION OF APPLICATIONS.—The
 5 Secretary shall develop a system for determining the
 6 priority for distributing grants under this section
 7 and such grants shall be distributed in accordance
 8 with such system.

9 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
 10 are authorized to be appropriated such sums as may be
 11 necessary for the purposes of awarding grants under this
 12 section.

13 “(d) DEFINITIONS.—For purposes of this section, the
 14 term “health network” has the same meaning given such
 15 term in section 311(c)(1) of the America’s Health Care
 16 Option Act.”.

17 **SEC. 313. COMMUNITY-BASED PRIMARY HEALTH CARE**
 18 **GRANT PROGRAM.**

19 Subpart I of part D of title III of the Public Health
 20 Service Act (42 U.S.C. 254b et seq.) is amended by adding
 21 at the end the following new section:

22 **“SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE**
 23 **GRANT PROGRAM.**

24 “(a) ESTABLISHMENT.—The Secretary shall estab-
 25 lish and administer a program to provide allotments to

1 States to enable such States to provide grants for the cre-
2 ation or enhancement of community-based primary health
3 care entities that provide services to low-income or medi-
4 cally underserved populations.

5 “(b) ALLOTMENTS TO STATES.—

6 “(1) IN GENERAL.—From the amount available
7 for allotment under subsection (h) for a fiscal year,
8 the Secretary shall allot to each State an amount
9 equal to the product of the grant share of the State
10 (as determined under paragraph (2)) multiplied by
11 such amount available.

12 “(2) GRANT SHARE.—

13 “(A) IN GENERAL.—For purposes of para-
14 graph (1), the grant share of a State shall be
15 the product of the need-adjusted population of
16 the State (as determined under subparagraph
17 (B)) multiplied by the Federal matching per-
18 centage of the State (as determined under sub-
19 paragraph (C)), expressed as a percentage of
20 the sum of the products of such factors for all
21 States.

22 “(B) NEED-ADJUSTED POPULATION.—

23 “(i) IN GENERAL.—For purposes of
24 subparagraph (A), the need-adjusted popu-
25 lation of a State shall be the product of

1 the total population of the State (as esti-
2 mated by the Secretary of Commerce) mul-
3 tiplied by the need index of the State (as
4 determined under clause (ii)).

5 “(ii) NEED INDEX.—For purposes of
6 clause (i), the need index of a State shall
7 be the ratio of—

8 “(I) the weighted sum of the geo-
9 graphic percentage of the State (as
10 determined under clause (iii)), the
11 poverty percentage of the State (as
12 determined under clause (iv)), and the
13 multiple grant percentage of the State
14 (as determined under clause (v)); to

15 “(II) the general population per-
16 centage of the State (as determined
17 under clause (vi)).

18 “(iii) GEOGRAPHIC PERCENTAGE.—

19 “(I) IN GENERAL.—For purposes
20 of clause (ii)(I), the geographic per-
21 centage of the State shall be the esti-
22 mated population of the State that is
23 residing in nonurbanized areas (as de-
24 termined under subclause (II)) ex-

1 pressed as a percentage of the total
2 nonurbanized population of all States.

3 “(II) NONURBANIZED POPU-
4 LATION.—For purposes of subclause
5 (I), the estimated population of the
6 State that is residing in nonurbanized
7 areas shall be one minus the urban-
8 ized population of the State (as deter-
9 mined using the most recent decennial
10 census), expressed as a percentage of
11 the total population of the State (as
12 determined using the most recent de-
13 cennial census), multiplied by the cur-
14 rent estimated population of the
15 State.

16 “(III) STATE OF ALASKA.—Not-
17 withstanding subclause (I), the geo-
18 graphic percentage for the State of
19 Alaska shall be the relative population
20 density of the State expressed as the
21 ratio of—

22 “(aa) the average number of
23 individuals residing in Alaska per
24 square mile; to

1 “(bb) the average number of
2 individuals residing in the United
3 States per square mile.

4 “(iv) POVERTY PERCENTAGE.—For
5 purposes of clause (ii)(I), the poverty per-
6 centage of the State shall be the estimated
7 number of people residing in the State
8 with incomes below 200 percent of the in-
9 come official poverty line (as adjusted for
10 actual costs and incomes in each State and
11 as determined by the Office of Manage-
12 ment and Budget) expressed as a percent-
13 age of the total number of such people re-
14 siding in all States.

15 “(v) MULTIPLE GRANT PERCENT-
16 AGE.—For purposes of clause (ii)(I), the
17 multiple grant percentage of the State
18 shall be the amount of Federal funding re-
19 ceived by the State under grants awarded
20 under sections 329, 330, and 340, ex-
21 pressed as a percentage of the total
22 amounts received under such grants by all
23 States. With respect to a State, such per-
24 centage shall not exceed twice the general
25 population percentage of the State under

1 clause (vi) or be less than one-half of the
2 States general population percentage.

3 “(vi) GENERAL POPULATION PER-
4 CENTAGE.—For purposes of clause (ii)(II),
5 the general population percentage of the
6 State shall be the total population of the
7 State (as determined by the Secretary of
8 Commerce) expressed as a percentage of
9 the total population of all States.

10 “(C) FEDERAL MATCHING PERCENTAGE.—

11 “(i) IN GENERAL.—For purposes of
12 subparagraph (A), the Federal matching
13 percentage of the State shall be equal to
14 one, less the State matching percentage (as
15 determined under clause (ii)).

16 “(ii) STATE MATCHING PERCENT-
17 AGE.—For purposes of clause (i), the State
18 matching percentage of the State shall be
19 0.25 multiplied by the ratio of the total
20 taxable resource percentage (as determined
21 under clause (iii)) to the need-adjusted
22 population of the State (as determined
23 under subparagraph (B)).

24 “(iii) TOTAL TAXABLE RESOURCE
25 PERCENTAGE.—For purposes of clause (ii),

1 the total taxable resources percentage of
2 the State shall be the total taxable re-
3 sources of a State (as determined by the
4 Secretary of the Treasury) expressed as a
5 percentage of the sum of the total taxable
6 resources of all States.

7 “(3) ANNUAL ESTIMATES.—

8 “(A) IN GENERAL.—If the Secretary of
9 Commerce does not produce the annual esti-
10 mates required under paragraph (2)(B)(iv),
11 such estimates shall be determined by multiply-
12 ing the percentage of the population of the
13 State that is below 200 percent of the income
14 official poverty line as determined using the
15 most recent decennial census by the most recent
16 estimate of the total population of the State.
17 Except as provided in subparagraph (B), the
18 calculations required under this subparagraph
19 shall be made based on the most recent 3-year
20 average of the total taxable resources of individ-
21 uals within the State.

22 “(B) DISTRICT OF COLUMBIA.—Notwith-
23 standing subparagraph (A), the calculations re-
24 quired under such subparagraph with respect to
25 the District of Columbia shall be based on the

1 most recent 3-year average of the personal in-
2 come of individuals residing within the District
3 as a percentage of the personal income for all
4 individuals residing within the District, as de-
5 termined by the Secretary of Commerce.

6 “(C) STATE OF ALASKA.—Notwithstanding
7 subparagraph (A), the calculations required
8 under such subparagraph with respect to the
9 State of Alaska shall be based on the quotient
10 of—

11 “(i) the most recent 3-year average of
12 the per capita income of individuals resid-
13 ing in the State; divided by

14 “(ii) 1.25.

15 “(4) MATCHING REQUIREMENT.—A State that
16 receives an allotment under this section shall make
17 available State resources (either directly or indi-
18 rectly) to carry out this section in an amount that
19 shall equal the State matching percentage for the
20 State (as determined under paragraph (2)(C)(ii)) di-
21 vided by the Federal matching percentage (as deter-
22 mined under paragraph (2)(C)).

23 “(c) APPLICATION.—

24 “(1) IN GENERAL.—To be eligible to receive an
25 allotment under this section, a State shall prepare

1 and submit an application to the Secretary at such
2 time, in such manner, and containing such informa-
3 tion as the Secretary may by regulation require.

4 “(2) ASSURANCES.—A State application sub-
5 mitted under paragraph (1) shall contain an assur-
6 ance that—

7 “(A) the State will use amounts received
8 under its allotment consistent with the require-
9 ments of this section; and

10 “(B) the State will provide, from non-Fed-
11 eral sources, the amounts required under sub-
12 section (b)(4).

13 “(d) USE OF FUNDS.—

14 “(1) IN GENERAL.—The State shall use
15 amounts received under this section to award grants
16 to eligible public and nonprofit private entities, or
17 consortia of such entities, within the State to enable
18 such entities or consortia to provide services of the
19 type described in paragraph (2) of section 329(h) to
20 low-income or medically underserved populations.

21 “(2) ELIGIBILITY.—To be eligible to receive a
22 grant under paragraph (1), an entity or consortium
23 shall—

24 “(A) prepare and submit to the admin-
25 istering entity of the State, an application at

1 such time, in such manner, and containing such
2 information as such administering entity may
3 require, including a plan for the provision of
4 services of the type described in paragraph (3);

5 “(B) provide assurances that services will
6 be provided under the grant at fee rates estab-
7 lished or determined in accordance with section
8 330(e)(3)(F); and

9 “(C) provide assurances that in the case of
10 services provided to individuals with health in-
11 surance, such insurance shall be used as the
12 primary source of payment for such services.

13 “(3) SERVICES.—The services to be provided
14 under a grant awarded under paragraph (1) shall in-
15 clude—

16 “(A) one or more of the types of primary
17 health services described in section 330(b)(1);

18 “(B) one or more of the types of supple-
19 mental health services described in section
20 330(b)(2); and

21 “(C) any other services determined appro-
22 priate by the administering entity of the State.

23 “(4) TARGET POPULATIONS.—Entities or con-
24 sortia receiving grants under paragraph (1) shall, in
25 providing the services described in paragraph (3),

1 substantially target populations of low-income or
2 medically underserved populations within the State
3 who reside in medically underserved or health pro-
4 fessional shortage areas, areas certified as under-
5 served under the rural health clinic program, or
6 other areas determined appropriate by the admin-
7 istering entity of the State, within the State.

8 “(5) PRIORITY.—In awarding grants under
9 paragraph (1), the State shall—

10 “(A) give priority to entities or consortia
11 that can demonstrate through the plan submit-
12 ted under paragraph (2) that—

13 “(i) the services provided under the
14 grant will expand the availability of pri-
15 mary care services to the maximum num-
16 ber of low-income or medically underserved
17 populations who have no access to such
18 care on the date of the grant award; and

19 “(ii) the delivery of services under the
20 grant will be cost-effective; and

21 “(B) ensure that an equitable distribution
22 of funds is achieved among urban and rural en-
23 tities or consortia.

24 “(e) REPORTS AND AUDITS.—Each State shall pre-
25 pare and submit to the Secretary annual reports concern-

1 ing the State's activities under this section which shall be
2 in such form and contain such information as the Sec-
3 retary determines appropriate. Each such State shall es-
4 tablish fiscal control and fund accounting procedures as
5 may be necessary to assure that amounts received under
6 this section are being disbursed properly and are ac-
7 counted for, and include the results of audits conducted
8 under such procedures in the reports submitted under this
9 subsection.

10 “(f) PAYMENTS.—

11 “(1) ENTITLEMENT.—Each State for which an
12 application has been approved by the Secretary
13 under this section shall be entitled to payments
14 under this section for each fiscal year in an amount
15 not to exceed the State's allotment under subsection
16 (b) to be expended by the State in accordance with
17 the terms of the application for the fiscal year for
18 which the allotment is to be made.

19 “(2) METHOD OF PAYMENTS.—The Secretary
20 may make payments to a State in installments, and
21 in advance or by way of reimbursement, with nec-
22 essary adjustments on account of overpayments or
23 underpayments, as the Secretary may determine.

24 “(3) STATE SPENDING OF PAYMENTS.—Pay-
25 ments to a State from the allotment under sub-

1 section (b) for any fiscal year must be expended by
2 the State in that fiscal year or in the succeeding fis-
3 cal year.

4 “(g) DEFINITION.—As used in this section, the term
5 ‘administering entity of the State’ means the agency or
6 official designated by the chief executive officer of the
7 State to administer the amounts provided to the State
8 under this section.

9 “(h) FUNDING.—Notwithstanding any other provi-
10 sion of law, the Secretary shall use 50 percent of the
11 amounts that the Secretary is required to utilize under
12 section 330B(h) in each fiscal year to carry out this sec-
13 tion.”.

14 **Subtitle B—Technical Assistance** 15 **Grants**

16 **SEC. 321. TECHNICAL ASSISTANCE GRANTS.**

17 (a) IN GENERAL.—The Secretary shall award grants
18 to public and private entities submitting applications that
19 are approved under subsection (b) for the purpose of pro-
20 viding technical assistance in the establishment of the in-
21 frastructure for health networks and plans in underserved
22 areas certified under section 302.

23 (b) APPLICATION PROCESS.—

24 (1) SUBMISSION OF APPLICATION.—Each entity
25 desiring to receive a grant under this section shall

1 submit an application to the Secretary at such time
2 and containing such information as the Secretary
3 determines appropriate, including—

4 (A) a description of the infrastructure uses
5 to which amounts awarded under a grant will
6 be allocated;

7 (B) a description of the area to be served
8 by the entity; and

9 (C) information demonstrating that the en-
10 tity has consulted with interested parties with
11 respect to the activities that the entity intends
12 to carry out with amounts received under the
13 grant, including local government entities and
14 community groups.

15 (2) CONSIDERATION OF APPLICATIONS.—The
16 Secretary shall develop a system for determining the
17 priority for distributing grants under this section
18 and such grants shall be distributed in accordance
19 with such system. The Secretary shall give priority
20 to applications that demonstrate partnerships among
21 health care providers and services (both public and
22 private) and effective coordination of all sources of
23 grants and other funding sources under this Act.

24 (c) AUTHORIZED USES.—Amounts received under a
25 grant awarded under this section may be used—

1 (1) for the design and establishment of the in-
2 frastructure necessary for the operation of a health
3 network or health plan in a rural, frontier or urban
4 underserved area;

5 (2) to assist health plans operating in rural,
6 frontier or urban underserved areas in meeting the
7 requirements of any subsidy program;

8 (3) to carry out activities to assist health care
9 providers in forming partnerships or health plans to
10 serve rural, frontier or urban underserved areas, in-
11 cluding assistance with the establishment of finan-
12 cial systems, computer systems, and telecommuni-
13 cations systems; and

14 (4) to carry out any other activity determined
15 appropriate by the Secretary.

16 (d) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated such sums as may be
18 necessary for the purposes of awarding grants under this
19 section.

20 (e) DEFINITIONS.—For purposes of this section, the
21 terms “health network”, “rural area”, “frontier area”,
22 and “urban underserved area” have the same meanings
23 given such terms in section 311(c).

1 **Subtitle C—Capital Assistance**
2 **Loans and Loan Guarantees**

3 **SEC. 331. RURAL, FRONTIER AND URBAN UNDERSERVED**
4 **AREA HEALTH LOAN PROGRAM.**

5 (a) IN GENERAL.—The Secretary shall make loans
6 to—

7 (1) health networks (as defined in section
8 311(c));

9 (2) health plans (as defined in section 21003(a)
10 of the Social Security Act) that cover individuals re-
11 siding in rural, frontier or urban underserved areas;
12 or

13 (3) health care providers that serve rural, fron-
14 tier or underserved urban areas;

15 for the capital costs of developing health delivery systems
16 and expanding existing health delivery sites to make
17 health care services available to individuals residing in un-
18 derserved areas certified under section 302.

19 (b) USE OF ASSISTANCE.—

20 (1) IN GENERAL.—The capital costs for which
21 loans made pursuant to subsection (a) may be ex-
22 pended are, subject to paragraphs (2) and (3), the
23 following:

24 (A) The modernization or expansion of fa-
25 cilities to reduce the inpatient characteristics of

1 such facilities while expanding the ambulatory
2 capabilities of such facilities, to enhance the
3 provision and accessibility of health care serv-
4 ices and practitioners to underserved popu-
5 lations.

6 (B) The conversion of unneeded facilities
7 to facilities that will assure or enhance the pro-
8 vision and accessibility of health care services
9 and practitioners to underserved populations, or
10 the closure of such facilities in an effort to con-
11 solidate clinical and administrative activities for
12 network purposes.

13 (C) The acquisition or modernization of fa-
14 cilities or purchase of land to facilitate the serv-
15 ice of rural, frontier and urban underserved
16 populations through health care networks or
17 health plans.

18 (D) The purchase of major equipment, in-
19 cluding equipment necessary for the support of
20 information systems, for the operation of a
21 health care network or a health care plan serv-
22 ing residents of rural, frontier and urban un-
23 derserved areas.

24 (E) The development and implementation
25 of systems (financial, quality assurance and

1 other systems) necessary to establish health
2 care networks.

3 (F) The development of appropriate pri-
4 mary care services and practitioners.

5 (G) The implementation of measures nec-
6 essary to enable a health care network, health
7 plan, or health care provider that serves rural,
8 frontier or urban underserved areas to comply
9 with applicable quality, safety or environmental
10 requirements.

11 (H) Such other capital costs as the Sec-
12 retary may determine are necessary to achieve
13 the objectives of this section, including start-up
14 expenses, reserve funds, and other financial re-
15 quirements applicable to networks, plans or pro-
16 viders.

17 (2) PRIORITIES REGARDING USE OF FUNDS.—

18 In providing loans under subsection (a) for an en-
19 tity, the Secretary shall give priority to authorizing
20 the use of amounts for projects for the renovation
21 and modernization of medical facilities necessary to
22 prevent or eliminate safety hazards, avoid non-
23 compliance with licensure or accreditation standards,
24 or projects to replace obsolete facilities.

1 (3) LIMITATION.—The Secretary may authorize
2 the use of loans under subsection (a) for the con-
3 struction of new buildings only if the Secretary de-
4 termines that appropriate facilities are not available
5 through acquiring, modernizing, expanding or con-
6 verting existing buildings, or that construction new
7 buildings will cost less.

8 (c) AMOUNT OF ASSISTANCE.—The principal amount
9 of loans under subsection (a) may cover up to 100 percent
10 of the costs involved.

11 **SEC. 332. CERTAIN REQUIREMENTS.**

12 (a) IN GENERAL.—The Secretary may approve a loan
13 under section 331 only if—

14 (1) an application for such assistance is submit-
15 ted to the Secretary in such form, is made in such
16 manner, and contains such agreements, assurances,
17 and information as the Secretary determines to be
18 necessary to carry out this subtitle;

19 (2) the Secretary is reasonably satisfied that
20 the applicant for the project for which the loan
21 would be made will be able to make payments of
22 principal and interest thereon when due; and

23 (3) the applicant provides the Secretary with
24 reasonable assurances that there will be available to
25 it such additional funds as may be necessary to com-

1 plete the project or undertaking with respect to
2 which such loan is requested.

3 (b) TERMS AND CONDITIONS.—Any loan made under
4 section 331 shall, subject to the Federal Credit Reform
5 Act of 1990, meet such terms and conditions (including
6 provisions for recovery in case of default) as the Secretary,
7 in consultation with the Secretary of the Treasury, deter-
8 mines to be necessary to carry out the purposes of such
9 section while adequately protecting the financial interests
10 of the United States. Terms and conditions for such loans
11 shall include provisions regarding the following:

12 (1) Security.

13 (2) Maturity date.

14 (3) Amount and frequency of installments.

15 (4) Rate of interest, which shall be at a rate
16 comparable to the rate of interest prevailing on the
17 date the loan is made.

18 **SEC. 333. DEFAULTS.**

19 (a) IN GENERAL.—The Secretary may take such ac-
20 tion as may be necessary to prevent a default on loans
21 under section 331, including the waiver of regulatory con-
22 ditions, deferral of loan payments, renegotiation of loans,
23 and the expenditure of funds for technical and consultative
24 assistance, for the temporary payment of the interest and
25 principal on such a loan, and for other purposes.

1 (b) FORECLOSURE.—The Secretary may take such
 2 action, consistent with State law respecting foreclosure
 3 procedures, as the Secretary deems appropriate to protect
 4 the interest of the United States in the event of a default
 5 on a loan made pursuant to section 331, including selling
 6 real property pledged as security for such a loan and for
 7 a reasonable period of time taking possession of, holding,
 8 and using real property pledged as security for such a
 9 loan.

10 (c) WAIVERS.—The Secretary may, for good cause,
 11 but with due regard to the financial interests of the United
 12 States, waive any right of recovery which the Secretary
 13 has by reasons of the failure of a borrower to make pay-
 14 ments of principal of and interest on a loan made pursu-
 15 ant to section 331, except that if such loan is sold and
 16 guaranteed, any such waiver shall have no effect upon the
 17 Secretary's guarantee of timely payment of principal and
 18 interest.

19 **Subtitle D—Increasing Primary** 20 **Care Providers**

21 **SEC. 341. NONREFUNDABLE CREDIT FOR CERTAIN PRI-** 22 **MARY HEALTH SERVICES PROVIDERS.**

23 (a) IN GENERAL.—Subpart A of part IV of sub-
 24 chapter A of chapter 1 of the Internal Revenue Code of
 25 1986 (relating to nonrefundable personal credits) is

1 amended by inserting after section 22 the following new
2 section:

3 **“SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.**

4 “(a) ALLOWANCE OF CREDIT.—There shall be al-
5 lowed as a credit against the tax imposed by this chapter
6 for the taxable year an amount equal to the product of—

7 “(1) the number of months during such taxable
8 year—

9 “(A) during which the taxpayer is a quali-
10 fied primary health services provider, and

11 “(B) which are within the taxpayer’s man-
12 datory service period, and

13 “(2) \$1,000 (\$500 in the case of a qualified
14 practitioner who is not a physician).

15 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-
16 VIDER.—For purposes of this section, the term ‘qualified
17 primary health services provider’ means, with respect to
18 any month, any qualified practitioner who—

19 “(1) has in effect a certification by the Bureau
20 as a provider of primary health services and such
21 certification is, when issued, for a health profes-
22 sional shortage area in which the qualified practi-
23 tioner is commencing the providing of primary
24 health services,

1 “(2) is providing primary health services full
2 time in the health professional shortage area identi-
3 fied in such certification, and

4 “(3) has not received a scholarship under the
5 National Health Service Corps Scholarship Program
6 or any loan repayments under the National Health
7 Service Corps Loan Repayment Program.

8 For purposes of paragraph (2) and subsection (e)(3), a
9 provider shall be treated as providing services in a health
10 professional shortage area when such area ceases to be
11 such an area if it was such an area when the provider
12 commenced providing services in the area.

13 “(c) MANDATORY SERVICE PERIOD.—For purposes
14 of this section, the term ‘mandatory service period’ means
15 the period of 60 consecutive calendar months beginning
16 with the first month the taxpayer is a qualified primary
17 health services provider. A taxpayer shall not have more
18 than 1 mandatory service period.

19 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
20 poses of this section—

21 “(1) BUREAU.—The term ‘Bureau’ means the
22 Bureau of Primary Health Care, Health Resources
23 and Services Administration of the United States
24 Public Health Service.

1 “(2) QUALIFIED PRACTITIONER.—The term
2 ‘qualified practitioner’ means a physician, a physi-
3 cian assistant, a nurse practitioner, or a certified
4 nurse-midwife.

5 “(3) PHYSICIAN.—The term ‘physician’ has the
6 meaning given to such term by section 1861(r) of
7 the Social Security Act.

8 “(4) PHYSICIAN ASSISTANT; NURSE PRACTI-
9 TIONER.—The terms ‘physician assistant’ and ‘nurse
10 practitioner’ have the meanings given to such terms
11 by section 1861(aa)(5) of the Social Security Act.

12 “(5) CERTIFIED NURSE-MIDWIFE.—The term
13 ‘certified nurse-midwife’ has the meaning given to
14 such term by section 1861(gg)(2) of the Social Secu-
15 rity Act.

16 “(6) PRIMARY HEALTH SERVICES.—The term
17 ‘primary health services’ has the meaning given such
18 term by section 330(b)(1) of the Public Health Serv-
19 ice Act.

20 “(7) HEALTH PROFESSIONAL SHORTAGE
21 AREA.—The term ‘health professional shortage area’
22 has the meaning given such term by section
23 332(a)(1)(A) of the Public Health Service Act.

24 “(e) RECAPTURE OF CREDIT.—

“(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

“(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

“(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

“(i) the applicable percentage, and

“(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

“(2) APPLICABLE RECAPTURE PERCENTAGE.—

“(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

“If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Month 61 or thereafter	0.

“(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

“(3) RECAPTURE EVENT DEFINED.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘recapture event’ means

1 the failure of the taxpayer to be a qualified pri-
 2 mary health services provider for any month
 3 during the taxpayer's mandatory service period.

4 “(B) SECRETARIAL WAIVER.—The Sec-
 5 retary, in consultation with the Secretary of
 6 Health and Human Services, may waive any re-
 7 capture event caused by extraordinary cir-
 8 cumstances.

9 “(4) NO CREDITS AGAINST TAX; MINIMUM
 10 TAX.—Any increase in tax under this subsection
 11 shall not be treated as a tax imposed by this chapter
 12 for purposes of determining the amount of any cred-
 13 it under subpart A, B, or D of this part or for pur-
 14 poses of section 55.”

15 (b) CLERICAL AMENDMENT.—The table of sections
 16 for subpart A of part IV of subchapter A of chapter 1
 17 of such Code is amended by inserting after the item relat-
 18 ing to section 22 the following new item:

“Sec. 23. Primary health services providers.”

19 (c) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to taxable years beginning after
 21 December 31, 1994.

22 **SEC. 342. EXPENSING OF MEDICAL EQUIPMENT.**

23 (a) IN GENERAL.—Paragraph (1) of section 179(b)
 24 of the Internal Revenue Code of 1986 (relating to dollar

1 limitation on expensing of certain depreciable business as-
2 sets) is amended to read as follows:

3 “(1) DOLLAR LIMITATION.—

4 “(A) GENERAL RULE.—The aggregate cost
5 which may be taken into account under sub-
6 section (a) for any taxable year shall not exceed
7 \$17,500.

8 “(B) HEALTH CARE PROPERTY.—The ag-
9 gregate cost which may be taken into account
10 under subsection (a) shall be increased by the
11 lesser of—

12 “(i) the cost of section 179 property
13 which is health care property placed in
14 service during the taxable year, or

15 “(ii) \$10,000.”

16 (b) DEFINITION.—Section 179(d) of such Code (re-
17 lating to definitions) is amended by adding at the end the
18 following new paragraph:

19 “(11) HEALTH CARE PROPERTY.—For purposes
20 of this section, the term ‘health care property’
21 means section 179 property—

22 “(A) which is medical equipment used in
23 the screening, monitoring, observation, diag-
24 nosis, or treatment of patients in a laboratory,
25 medical, or hospital environment,

1 “(B) which is owned (directly or indirectly)
2 and used by a physician (as defined in section
3 1861(r) of the Social Security Act) in the active
4 conduct of such physician’s full-time trade or
5 business of providing primary health services
6 (as defined in section 330(b)(1) of the Public
7 Health Service Act) in a health professional
8 shortage area (as defined in section
9 332(a)(1)(A) of the Public Health Service Act),
10 and

11 “(C) substantially all the use of which is in
12 such area.”

13 (c) RECAPTURE.—Paragraph (10) of section 179(d)
14 of such Code is amended by inserting before the period
15 “and with respect to any health care property which ceases
16 (other than by an area failing to be treated as a health
17 professional shortage area) to be health care property at
18 any time”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to property placed in service in
21 taxable years beginning after December 31, 1994.

22 **SEC. 343. EXPANDED SERVICES FOR MEDICALLY UNDER-**
23 **SERVED INDIVIDUALS.**

24 (a) IN GENERAL.—Subpart I of part D of title III
25 of the Public Health Service Act (42 U.S.C. 254b et seq.)

1 (as amended by section 313) is amended by adding at the
2 end the following new section:

3 **“SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDER-**
4 **SERVED INDIVIDUALS.**

5 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-
6 CESS PROGRAM.—From amounts appropriated under this
7 section, the Secretary shall, acting through the Bureau of
8 Health Care Delivery Assistance, award grants under this
9 section to federally qualified health centers (hereinafter re-
10 ferred to in this section as ‘FQHC’s’) and other entities
11 and organizations submitting applications under this sec-
12 tion (as described in subsection (c)) for the purpose of
13 providing access to services for medically underserved pop-
14 ulations (as defined in section 330(b)(3)) or in high im-
15 pact areas (as defined in section 329(a)(5)) not currently
16 being served by a FQHC.

17 “(b) ELIGIBILITY FOR GRANTS.—

18 “(1) IN GENERAL.—The Secretary shall award
19 grants under this section to entities or organizations
20 described in this paragraph and paragraph (2) which
21 have submitted a proposal to the Secretary to ex-
22 pand such entities or organizations operations (in-
23 cluding expansions to new sites (as determined nec-
24 essary by the Secretary)) to serve medically under-

1 served populations or high impact areas not cur-
2 rently served by a FQHC and which—

3 “(A) have as of January 1, 1991, been cer-
4 tified by the Secretary as a FQHC under sec-
5 tion 1905(l)(2)(B) of the Social Security Act;
6 or

7 “(B) have submitted applications to the
8 Secretary to qualify as FQHC’s under such sec-
9 tion 1905(l)(2)(B); or

10 “(C) have submitted a plan to the Sec-
11 retary which provides that the entity will meet
12 the requirements to qualify as a FQHC when
13 operational.

14 “(2) NON FQHC ENTITIES.—

15 “(A) ELIGIBILITY.—The Secretary shall
16 also make grants under this section to public or
17 private nonprofit agencies, health care entities
18 or organizations which meet the requirements
19 necessary to qualify as a FQHC except, the re-
20 quirement that such entity have a consumer
21 majority governing board and which have sub-
22 mitted a proposal to the Secretary to provide
23 those services provided by a FQHC as defined
24 in section 1905(l)(2)(B) of the Social Security
25 Act and which are designed to promote access

1 to primary care services or to reduce reliance on
2 hospital emergency rooms or other high cost
3 providers of primary health care services, pro-
4 vided such proposal is developed by the entity
5 or organizations (or such entities or organiza-
6 tions acting in a consortium in a community)
7 with the review and approval of the Governor of
8 the State in which such entity or organization
9 is located.

10 “(B) LIMITATION.—The Secretary shall
11 provide in making grants to entities or organi-
12 zations described in this paragraph that no
13 more than 10 percent of the funds provided for
14 grants under this section shall be made avail-
15 able for grants to such entities or organizations.

16 “(c) APPLICATION REQUIREMENTS.—

17 “(1) IN GENERAL.—In order to be eligible to
18 receive a grant under this section, a FQHC or other
19 entity or organization must submit an application in
20 such form and at such time as the Secretary shall
21 prescribe and which meets the requirements of this
22 subsection.

23 “(2) REQUIREMENTS.—An application submit-
24 ted under this section must provide—

1 “(A)(i) for a schedule of fees or payments
2 for the provision of the services provided by the
3 entity designed to cover its reasonable costs of
4 operations; and

5 “(ii) for a corresponding schedule of dis-
6 counts to be applied to such fees or payments,
7 based upon the patient’s ability to pay (deter-
8 mined by using a sliding scale formula based on
9 the income of the patient);

10 “(B) assurances that the entity or organi-
11 zation provides services to persons who are eli-
12 gible for benefits under title XVIII of the Social
13 Security Act, for medical assistance under title
14 XIX of such Act or for assistance for medical
15 expenses under any other public assistance pro-
16 gram or private health insurance program; and

17 “(C) assurances that the entity or organi-
18 zation has made and will continue to make
19 every reasonable effort to collect reimbursement
20 for services—

21 “(i) from persons eligible for assist-
22 ance under any of the programs described
23 in subparagraph (B); and

24 “(ii) from patients not entitled to ben-
25 efits under any such programs.

1 “(d) LIMITATIONS ON USE OF FUNDS.—

2 “(1) IN GENERAL.—From the amounts award-
3 ed to an entity or organization under this section,
4 funds may be used for purposes of planning but may
5 only be expended for the costs of—

6 “(A) assessing the needs of the populations
7 or proposed areas to be served;

8 “(B) preparing a description of how the
9 needs identified will be met; and

10 “(C) development of an implementation
11 plan that addresses—

12 “(i) recruitment and training of per-
13 sonnel; and

14 “(ii) activities necessary to achieve
15 operational status in order to meet FQHC
16 requirements under 1905(l)(2)(B) of the
17 Social Security Act.

18 “(2) RECRUITING, TRAINING AND COMPENSA-
19 TION OF STAFF.—From the amounts awarded to an
20 entity or organization under this section, funds may
21 be used for the purposes of paying for the costs of
22 recruiting, training and compensating staff (clinical
23 and associated administrative personnel (to the ex-
24 tent such costs are not already reimbursed under
25 title XIX of the Social Security Act or any other

1 State or Federal program)) to the extent necessary
2 to allow the entity to operate at new or expended ex-
3 isting sites.

4 “(3) FACILITIES AND EQUIPMENT.—From the
5 amounts awarded to an entity or organization under
6 this section, funds may be expended for the purposes
7 of acquiring facilities and equipment but only for the
8 cost of—

9 “(A) construction of new buildings (to the
10 extent that new construction is found to be the
11 most cost-efficient approach by the Secretary);

12 “(B) acquiring, expanding, and moderniz-
13 ing of existing facilities;

14 “(C) purchasing essential (as determined
15 by the Secretary) equipment; and

16 “(D) amortization of principal and pay-
17 ment of interest on loans obtained for purposes
18 of site construction, acquisition, modernization,
19 or expansion, as well as necessary equipment.

20 “(4) SERVICES.—From the amounts awarded
21 to an entity or organization under this section, funds
22 may be expended for the payment of services but
23 only for the costs of—

24 “(A) providing or arranging for the provi-
25 sion of all services through the entity necessary

1 to qualify such entity as a FQHC under section
2 1905(l)(2)(B) of the Social Security Act;

3 “(B) providing or arranging for any other
4 service that a FQHC may provide and be reim-
5 bursed for under title XIX of such Act; and

6 “(C) providing any unreimbursed costs of
7 providing services as described in section 330(a)
8 to patients.

9 “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

10 “(1) CERTIFIED FQHC’s.—The Secretary shall
11 give priority in awarding grants under this section
12 to entities which have, as of January 1, 1991, been
13 certified as a FQHC under section 1905(l)(2)(B) of
14 the Social Security Act and which have submitted a
15 proposal to the Secretary to expand their operations
16 (including expansion to new sites) to serve medically
17 underserved populations for high impact areas not
18 currently served by a FQHC. The Secretary shall
19 give first priority in awarding grants under this sec-
20 tion to those FQHCs or other entities which propose
21 to serve populations with the highest degree of
22 unmet need, and which can demonstrate the ability
23 to expand their operations in the most efficient man-
24 ner.

1 “(2) QUALIFIED FQHC’S.—The Secretary shall
2 give second priority in awarding grants to entities
3 which have submitted applications to the Secretary
4 which demonstrate that the entity will qualify as a
5 FQHC under section 1905(l)(2)(B) of the Social Se-
6 curity Act before it provides or arranges for the pro-
7 vision of services supported by funds awarded under
8 this section, and which are serving or proposing to
9 serve medically underserved populations or high im-
10 pact areas which are not currently served (or pro-
11 posed to be served) by a FQHC.

12 “(3) EXPANDED SERVICES AND PROJECTS.—
13 The Secretary shall give third priority in awarding
14 grants in subsequent years to those FQHCs or other
15 entities which have provided for expanded services
16 and project and are able to demonstrate that such
17 entity will incur significant unreimbursed costs in
18 providing such expanded services.

19 “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS
20 REIMBURSED FROM OTHER SOURCES.—To the extent
21 that an entity or organization receiving funds under this
22 section is reimbursed from another source for the provi-
23 sion of services to an individual, and does not use such
24 increased reimbursement to expand services furnished,
25 areas served, to compensate for costs of unreimbursed

1 services provided to patients, or to promote recruitment,
2 training, or retention of personnel, such excess revenues
3 shall be returned to the Secretary.

4 “(g) TERMINATION OF GRANTS.—

5 “(1) FAILURE TO MEET FQHC REQUIRE-
6 MENTS.—

7 “(A) IN GENERAL.—With respect to any
8 entity that is receiving funds awarded under
9 this section and which subsequently fails to
10 meet the requirements to qualify as a FQHC
11 under section 1905(l)(2)(B) or is an entity that
12 is not required to meet the requirements to
13 qualify as a FQHC under section 1905(l)(2)(B)
14 of the Social Security Act but fails to meet the
15 requirements of this section, the Secretary shall
16 terminate the award of funds under this section
17 to such entity.

18 “(B) NOTICE.—Prior to any termination
19 of funds under this section to an entity, the en-
20 tities shall be entitled to 60 days prior notice of
21 termination and, as provided by the Secretary
22 in regulations, an opportunity to correct any de-
23 ficiencies in order to allow the entity to con-
24 tinue to receive funds under this section.

1 “(2) REQUIREMENTS.—Upon any termination
2 of funding under this section, the Secretary may (to
3 the extent practicable)—

4 “(A) sell any property (including equip-
5 ment) acquired or constructed by the entity
6 using funds made available under this section
7 or transfer such property to another FQHC,
8 provided, that the Secretary shall reimburse
9 any costs which were incurred by the entity in
10 acquiring or constructing such property (includ-
11 ing equipment) which were not supported by
12 grants under this section; and

13 “(B) recoup any funds provided to an en-
14 tity terminated under this section.

15 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 \$100,000,000 for each of the fiscal years 1996 through
18 1999.”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall become effective with respect to serv-
21 ices furnished by a federally qualified health center or
22 other qualifying entity described in this section beginning
23 on or after October 1, 1995.

1 **SEC. 344. ACCUMULATION OF RESERVES BY CERTAIN ENTI-**
2 **TIES.**

3 Any organization referred to in section 329, 330, or
4 340 of the Public Health Service Act may accumulate re-
5 serves.

6 **SEC. 345. MATERNAL AND INFANT CARE COORDINATION.**

7 (a) PURPOSE.—It is the purpose of this section to
8 assist States in the development and implementation of
9 coordinated, multidisciplinary, and comprehensive primary
10 health care and social services, and health and nutrition
11 education programs, designed to improve maternal and
12 child health.

13 (b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

14 (1) AUTHORITY.—The Secretary of Health and
15 Human Services (hereafter referred to in this section
16 as the “Secretary”) is authorized to award grants to
17 States to enable such States to plan and implement
18 coordinated, multidisciplinary, and comprehensive
19 primary health care and social service programs tar-
20 geted to pregnant women and infants.

21 (2) ELIGIBILITY.—To be eligible to receive a
22 grant under this section, a State shall—

23 (A) prepare and submit to the Secretary
24 an application at such time, in such manner,
25 and containing such information as the Sec-
26 retary may require;

1 (B) as part of the State application, pro-
2 vide assurances that under the program estab-
3 lished with amounts received under a grant, in-
4 dividuals will have access to a broad range of
5 primary health care services, social services,
6 and health and nutrition programs designed to
7 improve maternal and child health and a de-
8 scription of how coordination of such services
9 will improve maternal and child health based
10 upon the goals of “Healthy People 2000: Na-
11 tional Health Promotion and Disease Preven-
12 tion Objectives”;

13 (C) as part of the State application, sub-
14 mit a plan for the coordination of existing and
15 proposed Federal and State resources, as ap-
16 propriate, including amounts provided under
17 the medicaid program under title XIX of the
18 Social Security Act, the special supplemental
19 food program under section 17 of the Child Nu-
20 trition Act of 1966, family planning programs,
21 substance abuse programs, State maternal and
22 child health programs funded under title V of
23 the Social Security Act, community and mi-
24 grant health center programs under the Public

1 Health Service Act, and other publicly, or where
2 practicable, privately supported programs;

3 (D) demonstrate that the major service
4 providers to be involved, including private non-
5 profit entities committed to improving maternal
6 and infant health, are committed to and in-
7 volved in the program to be funded with
8 amounts received under the grant;

9 (E) with respect to States with high infant
10 mortality rates among minority populations,
11 demonstrate the involvement of major health,
12 multiservice, professional, or civic group rep-
13 resentatives of such minority groups in the
14 planning and implementation of the State pro-
15 gram; and

16 (F) demonstrate that activities under the
17 State program are targeted to women of child-
18 bearing age, particularly those at risk for hav-
19 ing low birth weight babies.

20 (3) TERM OF GRANT.—A grant awarded under
21 this subsection shall be for a period of 5 years.

22 (4) USE OF AMOUNTS.—Amounts received by a
23 State under a grant awarded under this subsection
24 shall be used to establish a State program to provide
25 coordinated, multidisciplinary, and comprehensive

1 primary health care and social services, and health
 2 and nutrition education program services, that are
 3 designed to improve maternal and child health. Such
 4 amounts shall not be used for the construction of
 5 buildings or the purchase of medical equipment.

6 (5) MAINTENANCE OF EFFORT.—Any funds re-
 7 ceived by a State under this subsection shall supple-
 8 ment, and shall not supplant, funds that are ex-
 9 pended for similar purposes by the State.

10 (6) AUTHORIZATION OF APPROPRIATIONS.—
 11 There are authorized to be appropriated such sums
 12 as may be necessary to carry out the purposes of
 13 this subsection for fiscal years 1995 through 1998.

14 **SEC. 346. PRE-SCHOOL AND ELEMENTARY SCHOOL HEALTH**
 15 **EDUCATION PROGRAMS.**

16 Section 4605 of the Elementary and Secondary Edu-
 17 cation Act of 1965 (20 U.S.C. 3155) is amended to read
 18 as follows:

19 **“SEC. 4605. PRE-SCHOOL AND ELEMENTARY SCHOOL**
 20 **HEALTH EDUCATION PROGRAMS.**

21 “(a) PURPOSE.—It is the purpose of this section to
 22 establish a comprehensive school health education and pre-
 23 vention program for pre-school and elementary school stu-
 24 dents.

1 “(b) PROGRAM AUTHORIZED.—The Secretary shall
2 award grants to States to enable such States to—

3 “(1) award grants to local or intermediate edu-
4 cational agencies, and consortia thereof, to enable
5 such agencies or consortia to establish, operate and
6 improve local programs of comprehensive health edu-
7 cation and prevention, early health intervention, and
8 health education, in pre-school and elementary
9 schools; and

10 “(2) develop training, technical assistance and
11 coordination activities for the programs assisted pur-
12 suant to paragraph (1).

13 “(c) USE OF FUNDS.—Grant funds under this sec-
14 tion may be used to improve pre-school and elementary
15 school education in the areas of—

16 “(1) personal health and fitness;

17 “(2) prevention of chronic diseases;

18 “(3) prevention and control of communicable
19 diseases;

20 “(4) nutrition;

21 “(5) substance use and abuse;

22 “(6) accident prevention and safety;

23 “(7) community and environmental health;

24 “(8) mental and emotional health; and

1 “(9) the effective use of the health services de-
2 livery system.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—

4 “(1) IN GENERAL.—There are authorized to be
5 appropriated such sums as may be necessary to
6 carry out the purposes of this section for fiscal years
7 1996 through 2000.

8 “(2) AVAILABILITY.—Funds appropriated pur-
9 suant to the authority of paragraph (1) in any fiscal
10 year shall remain available for obligation and ex-
11 penditure until the end of the fiscal year succeeding
12 the fiscal year for which such funds were appro-
13 priated.”.

14 **SEC. 347. FRONTIER STATES.**

15 (a) IN GENERAL.—Frontier States (including Alaska,
16 Wyoming and Montana) may implement proposals to offer
17 preventive services, including mobile preventive health cen-
18 ters which may include centers equipped with various pre-
19 ventive health services, such as mammography, eye care,
20 X-ray, and other advanced equipment, and which may be
21 located on aircraft, watercraft, or other forms of transpor-
22 tation.

23 (b) DEMONSTRATION PROJECTS.—Frontier States
24 may participate in demonstration projects under this or
25 any other Act to improve recruitment, retention, and

1 training of rural providers, including nurse practitioners
2 and physician assistants. Such demonstration projects
3 shall give special consideration to the diverse needs of
4 Frontier States, and shall involve cooperative agreements
5 with a range of service delivery systems and teaching hos-
6 pitals.

7 **SEC. 348. INCREASE IN NATIONAL HEALTH SERVICE CORPS**
8 **AND AREA HEALTH EDUCATION CENTER**
9 **FUNDING.**

10 (a) NATIONAL HEALTH SERVICE CORPS.—Section
11 338H(b)(1) of the Public Health Service Act (42 U.S.C.
12 254q(b)(1)) is amended—

13 (1) by striking “1991, and” and inserting
14 “1991,”; and

15 (2) by striking “through 2000” and inserting “,
16 1993, and 1994, and \$20,000,000 for each of the
17 fiscal years 1995 through 2000”.

18 (b) AREA HEALTH EDUCATION CENTERS.—Section
19 746(i)(1) of such Act (42 U.S.C. 293j(i)(1)) is amended—

20 (1) in subparagraph (A), by striking “1995”
21 and inserting “1995, and \$20,000,000 for each of
22 the fiscal years 1996 through 2000”; and

23 (2) in subparagraph (C), by striking “and
24 1995” and inserting “1995, and \$20,000,000 for
25 each of the fiscal years 1996 through 2000”.

1 **SEC. 349. TELEMEDICINE FEDERAL INTERAGENCY TASK**
2 **FORCE.**

3 (a) ESTABLISHMENT.—Not later than 90 days after
4 the date of the enactment of this section, the Secretary
5 of Health and Human Services shall establish a Federal
6 interagency task force to be known as the ‘Interagency
7 Task Force on Rural Telemedicine’ (hereafter in this sec-
8 tion referred to as the “Task Force”).

9 (b) DUTIES.—

10 (1) IN GENERAL.—The Task Force shall—

11 (A) identify specific uses for telemedicine
12 that have been proven to be effective to be used
13 in the evaluation of applications for federally
14 funded telemedicine demonstration projects, in-
15 cluding any application submitted under this
16 part;

17 (B) review and coordinate evaluations of
18 all federally funded telemedicine and tele-
19 communications infrastructure demonstration
20 projects, including any demonstration project
21 established under this subtitle;

22 (C) establish mechanisms to facilitate a
23 local area needs assessment and consortium de-
24 velopment process to assist entities conducting
25 federally funded telemedicine demonstration

1 projects, including demonstration projects
2 under this part; and

3 (D) review the provision of telemedicine
4 services under the demonstration projects estab-
5 lished under section 350.

6 (2) PUBLICATION OF RESULTS.—Not later than
7 2 years after the Task Force is established, and an-
8 nually thereafter, the Task Force shall analyze and
9 publish a report of its findings under subparagraphs
10 (A) through (D) of paragraph (1) and shall make
11 such publications available to the Congress and the
12 general public.

13 (c) MEMBERSHIP.—

14 (1) IN GENERAL.—The Task Force shall con-
15 sist of representatives of—

16 (A) the Department of Health and Human
17 Services;

18 (B) the Rural Electrification Administra-
19 tion;

20 (C) the National Telecommunications In-
21 formation Agency;

22 (D) the National Institutes of Health; and

23 (E) other agencies and departments that
24 have responsibility for overseeing telemedicine
25 projects.

1 (2) CHAIRPERSON.—A representative of the De-
2 partment of Health and Human Services shall serve
3 as the chairperson of the Task Force.

4 (d) BASIC PAY.—Each member of the Task Force
5 shall serve without pay.

6 (e) MEETINGS.—The Task Force shall meet at the
7 call of the chairperson.

8 (f) QUORUM.—A majority of the members shall con-
9 stitute a quorum for the transaction of business.

10 **SEC. 350. DEMONSTRATION PROJECTS TO PROMOTE**
11 **TELEMEDICINE.**

12 (a) DEFINITIONS.—For purposes of this section:

13 (1) RURAL HEALTH CARE PROVIDER.—The
14 term “rural health care provider” means any public
15 or private health care provider located in a rural
16 area.

17 (2) NONHEALTH CARE ENTITY.—The term
18 “nonhealth care entity” means any entity that is not
19 involved in the provision of health care, including a
20 business, educational institution, library, and prison.

21 (b) ESTABLISHMENT.—The Secretary, acting
22 through the Office of Rural Health, shall award grants
23 to eligible entities to establish demonstration projects
24 under which an eligible entity establishes a rural-based

1 consortium that enables members of the consortium to uti-
2 lize the telecommunications network—

3 (1) to strengthen the delivery of health care
4 services in the rural area through the use of
5 telemedicine;

6 (2) to provide for consultations involving trans-
7 missions of detailed data about the patient that
8 serves as a reasonable substitute for face-to-face
9 interaction between the patient and consultant; and

10 (3) to make outside resources or business inter-
11 action more available to the rural area.

12 (c) ELIGIBLE ENTITY.—To be eligible to receive a
13 grant under this section an applicant entity shall propose
14 a consortium that includes as members at least—

15 (1) one rural health care provider; and

16 (2) one nonhealth care entity located in the
17 same rural area as the rural health care provider de-
18 scribed in paragraph (1).

19 The Secretary may waive the membership requirement
20 under paragraph (2) if the members described in para-
21 graph (1) are unable to locate a nonhealth care entity lo-
22 cated in the same rural area to participate in the dem-
23 onstration project.

24 (d) APPLICATION.—To be eligible to receive a grant
25 under this section, an eligible entity described in sub-

1 section (c) shall prepare and submit to the Secretary an
2 application at such time, in such manner, and containing
3 such information as the Secretary may require, including
4 a description of the use to which the eligible entity would
5 apply any amounts received under such grant, the source
6 and amount of non-Federal funds the entity would pledge
7 for the project, and a showing of the long-term sustain-
8 ability of the project.

9 (e) GRANTS.—Grants under this section shall be dis-
10 tributed in accordance with the following requirements:

11 (1) GRANT LIMIT.—The Secretary may not
12 make a grant to an eligible entity under this section
13 in excess of \$500,000 for each fiscal year in which
14 an eligible entity conducts a project under this sec-
15 tion.

16 (2) MATCHING FUNDS.—

17 (A) IN GENERAL.—The Secretary may not
18 make a grant to an eligible entity under this
19 section unless the eligible entity agrees to pro-
20 vide non-Federal funds in an amount equal to
21 not less than 20 percent of the total amount to
22 be expended by the eligible entity in any fiscal
23 year for the purpose of conducting the project
24 under this section.

1 (B) ADJUSTMENTS.—The Secretary shall
2 make necessary adjustments to the amount that
3 an eligible entity may receive in a subsequent
4 fiscal year if the eligible entity does not meet
5 the requirements of subparagraph (A) in the
6 preceding fiscal year.

7 (f) USE OF GRANT AMOUNTS.—

8 (1) IN GENERAL.—Amounts received under a
9 grant awarded under this section shall be utilized for
10 the development and operation of telemedicine sys-
11 tems that serve rural areas. All such grant funds
12 must be used to further the provision of health serv-
13 ices to rural areas.

14 (2) RULES OF USE.—

15 (A) PERMISSIBLE USAGES.—Grant funds
16 awarded under this section—

17 (i) shall primarily be used to support
18 the costs of establishing and operating a
19 telemedicine system that provides specialty
20 consultations to rural communities;

21 (ii) may be used to demonstrate the
22 application of telemedicine for preceptor-
23 ship of medical students, residents, and
24 other health professions students in rural
25 training sites;

1 (iii) may be used for transmission
2 costs, salaries, maintenance of equipment,
3 and compensation of specialists and refer-
4 ring practitioners;

5 (iv) may be used to pay the fees of
6 consultants, but only to the extent that the
7 total of such fees do not exceed 5 percent
8 of the amount of the grant;

9 (v) may be used to demonstrate the
10 use of telemedicine to facilitate collabora-
11 tion between non-physician primary care
12 practitioners (including physician assist-
13 ants, nurse practitioners, certified nurse-
14 midwives, and clinical nurse specialists)
15 and physicians; and

16 (vi) may be used to test reimburse-
17 ment methodologies under the medicare
18 program under title XVIII of the Social
19 Security Act and the medicaid program
20 under title XIX of such Act for practition-
21 ers participating in telemedicine activities.

22 (B) PROHIBITED USE OF FUNDS.—Grant
23 funds shall not be used by members of a rural-
24 based consortium for any of the following:

1 (i) Expenditures to purchase or lease
2 equipment.

3 (ii) In the case of a member of a con-
4 sortium that is an isolated rural facility,
5 purchase of high-cost telecommunications
6 technologies for the furnishing of
7 telemedicine services that—

8 (I) incur high cost per minute of
9 usage charges; or

10 (II) require consultants to be
11 available at the same time as the pa-
12 tient and the referring physician.

13 (iii) Purchase or installation of trans-
14 mission equipment or establishment or op-
15 eration of a telecommunications common
16 carrier network.

17 (iv) Expenditures for indirect costs
18 (as determined by the Secretary) to the ex-
19 tent the expenditures would exceed more
20 than 20 percent of the total grant funds.

21 (v) Construction (except for minor
22 renovations related to the installation of
23 equipment), or the acquisition or building
24 of real property.

1 (g) MAINTENANCE OF EFFORT.—Any funds available
 2 for the activities covered by a demonstration project con-
 3 ducted under this section shall supplement, and shall not
 4 supplant, funds that are expended for similar purposes
 5 under any State, regional, or local program.

6 (h) EVALUATIONS.—Each eligible entity that con-
 7 ducts a demonstration project under this section shall sub-
 8 mit to the Secretary such information and interim evalua-
 9 tions as the Secretary may require. The Secretary shall
 10 provide the Interagency Task Force on Rural
 11 Telemedicine with such evaluations and information sub-
 12 mitted under the previous sentence as the Task Force may
 13 required to carry out its duties under section 345(b).

14 (i) AUTHORIZATION OF APPROPRIATIONS.—There
 15 are authorized to be appropriated to carry out this section,
 16 \$10,000,000 for each of the fiscal years 1995 through
 17 1997.

18 **Subtitle E—Payment Flexibility**

19 **SEC. 351. ESSENTIAL ACCESS COMMUNITY HOSPITAL** 20 **(EACH) AMENDMENTS.**

21 (a) UNLIMITED PARTICIPATING STATES; ELIMI-
 22 NATION OF GRANT TIE-IN.—

23 (1) IN GENERAL.—Section 1820(a) of the So-
 24 cial Security Act (42 U.S.C. 1395i-4(a)) is amended
 25 to read as follows:

1 “(a) IN GENERAL.—

2 “(1) PROGRAM DESCRIBED.—There is hereby
3 established a program under which the Secretary—

4 “(A) shall permit States that have submit-
5 ted an application in accordance with subsection
6 (b) to carry out the activities described in sub-
7 sections (e) and (f); and

8 “(B) shall designate (under subsection (i))
9 hospitals and facilities located in States partici-
10 pating in a program under this section as es-
11 sential access community hospitals or rural pri-
12 mary care hospitals.

13 “(2) AVAILABILITY OF GRANTS.—

14 “(A) STATES.—The Secretary shall make
15 grants available to selected States described in
16 paragraph (1)(A) to carry out the activities de-
17 scribed in subsection (d)(1).

18 “(B) ELIGIBLE HOSPITALS AND FACILI-
19 TIES.—The Secretary shall make grants avail-
20 able to selected eligible hospitals and facilities
21 (or consortia of hospitals and facilities) to carry
22 out the activities described in subsection
23 (d)(2).’.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 1820(b) of such Act (42
2 U.S.C. 1395i-4(b)) is amended by striking
3 “ELIGIBILITY OF STATES FOR GRANTS.—”
4 through “subsection (a)(1)” and inserting “AP-
5 PLICATION.—A State is eligible to participate in
6 the program described in this section”.

7 (B) Section 1820(c) of such Act (42
8 U.S.C. 1395i-4(c)) is amended—

9 (i) in paragraph (1)—

10 (I) in the matter preceding sub-
11 paragraph (A), by striking “(a)(2)”
12 and inserting “(a)(2)(B)”, and

13 (II) in subparagraph (A), by
14 striking “receiving a grant under sub-
15 section (a)(1)” and inserting “partici-
16 pating in the program under this sec-
17 tion”; and

18 (ii) in paragraph (3)—

19 (I) by striking “STATE RECEIV-
20 ING GRANT.—” and inserting “STATE
21 PARTICIPATING IN THE PROGRAM.—”,
22 and

23 (II) by striking “(a)(2)” and in-
24 serting “(a)(2)(B)”.

1 (C) Section 1820(d) of such Act (42
2 U.S.C. 1395i-4(d)) is amended—

3 (i) in paragraph (1), by striking
4 “(a)(1)” and inserting “(a)(2)(A)”; and

5 (ii) in paragraph (2), by striking
6 “(a)(2)” each place it appears and and in-
7 serting “(a)(2)(B)”.

8 (C) Section 1820(i) of such Act (42 U.S.C.
9 1395i-4(i)) is amended—

10 (i) in paragraph (1)(A)(i), by striking
11 “receiving a grant under subsection
12 (a)(1)” and inserting “participating in the
13 program under this section”; and

14 (ii) in paragraph (2)(A)(i), by striking
15 “receiving a grant under subsection
16 (a)(1)” and inserting “participating in the
17 program under this section”.

18 (b) TREATMENT OF INPATIENT HOSPITAL SERVICES
19 PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

20 (1) IN GENERAL.—Section 1820(f)(1)(F) of the
21 Social Security Act (42 U.S.C. 1395i-4(f)(1)(F)) is
22 amended to read as follows:

23 “(F) subject to paragraph (4), provides not
24 more than 6 inpatient beds (meeting such con-
25 ditions as the Secretary may establish) for pro-

1 viding inpatient care to patients requiring sta-
2 bilization before discharge or transfer to a hos-
3 pital, except that the facility may not provide
4 any inpatient hospital services consisting of sur-
5 gery or any other service requiring the use of
6 general anesthesia (other than surgical proce-
7 dures specified by the Secretary under section
8 1833(i)(1)(A)) unless the attending physician
9 certifies that the risk associated with transfer-
10 ring the patient to a hospital for such services
11 outweighs the benefits of transferring the pa-
12 tient to a hospital for such services.”.

13 (2) LIMITATION ON AVERAGE LENGTH OF
14 STAY.—Section 1820(f) of such Act (42 U.S.C.
15 1395i–4(f)) is amended by adding at the end the fol-
16 lowing new paragraph:

17 “(4) LIMITATION ON AVERAGE LENGTH OF IN-
18 PATIENT STAYS.—The Secretary may terminate a
19 designation of a rural primary care hospital under
20 paragraph (1) if the Secretary finds that the average
21 length of stay for inpatients at the facility during
22 the previous year in which the designation was in ef-
23 fect exceeded 72 hours. In determining the compli-
24 ance of a facility with the requirement of the pre-
25 vious sentence, there shall not be taken into account

1 periods of stay of inpatients in excess of 72 hours
2 to the extent such periods exceed 72 hours because
3 transfer to a hospital is precluded because of inclem-
4 ent weather or other emergency conditions.”.

5 (3) CONFORMING AMENDMENT.—Section
6 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is
7 amended by striking “such services” and all that fol-
8 lows and inserting “the individual may reasonably be
9 expected to be discharged or transferred to a hos-
10 pital within 72 hours after admission to the rural
11 primary care hospital.”.

12 (4) GAO REPORTS.—Not later than 2 years
13 after the date of the enactment of this Act, the
14 Comptroller General shall submit reports to Con-
15 gress on—

16 (A) the application of the requirement
17 under section 1820(f) of the Social Security Act
18 (as amended by this subsection) that rural pri-
19 mary care hospitals maintain an average length
20 of inpatient stay during a year that does not
21 exceed 72 hours; and

22 (B) the extent to which such requirement
23 has resulted in such hospitals providing inpa-
24 tient care beyond their capabilities or have lim-

1 ited the ability of such hospitals to provide
2 needed services.

3 (c) DESIGNATION OF HOSPITALS.—

4 (1) PERMITTING DESIGNATION OF HOSPITALS
5 LOCATED IN URBAN AREAS.—

6 (A) IN GENERAL.—Section 1820 of the So-
7 cial Security Act (42 U.S.C. 1395i-4) is
8 amended—

9 (i) by striking paragraph (1) of sub-
10 section (e) and redesignating paragraphs
11 (2) through (6) as paragraphs (1) through
12 (5);

13 (ii) in subsection (e)(1)(A) (as redes-
14 ignated by subparagraph (A))—

15 (I) by striking “is located” and
16 inserting “except in the case of a hos-
17 pital located in an urban area, is lo-
18 cated”,

19 (II) by striking “, (ii)” and in-
20 serting “or (ii)”, and

21 (III) by striking “or (iii)” and all
22 that follows through “section,”; and

23 (iii) in subsection (i)(1)(B), by strik-
24 ing “paragraph (3)” and inserting “para-
25 graph (2)”.

1 (B) NO CHANGE IN MEDICARE PROSPEC-
 2 TIVE PAYMENT.—Section 1886(d)(5)(D) of
 3 such Act (42 U.S.C. 1395ww(d)(5)(D)) is
 4 amended—

5 (i) in clause (iii)(III), by inserting “lo-
 6 cated in a rural area and” after “that is”,
 7 and

8 (ii) in clause (v), by inserting “located
 9 in a rural area and” after “in the case of
 10 a hospital”.

11 (2) PERMITTING HOSPITALS LOCATED IN AD-
 12 JOINING STATES TO PARTICIPATE IN STATE PRO-
 13 GRAM.—

14 (A) IN GENERAL.—Section 1820 of such
 15 Act (42 U.S.C. 1395i-4) is amended—

16 (i) by redesignating subsection (k) as
 17 subsection (l); and

18 (ii) by inserting after subsection (j)
 19 the following new subsection:

20 “(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN
 21 PARTICIPATING STATES.—Notwithstanding any other
 22 provision of this section—

23 “(1) for purposes of including a hospital or fa-
 24 cility as a member institution of a rural health net-
 25 work, a State may designate a hospital or facility

1 that is not located in the State as an essential access
2 community hospital or a rural primary care hospital
3 if the hospital or facility is located in an adjoining
4 State and is otherwise eligible for designation as
5 such a hospital;

6 “(2) the Secretary may designate a hospital or
7 facility that is not located in a State receiving a
8 grant under subsection (a)(1) as an essential access
9 community hospital or a rural primary care hospital
10 if the hospital or facility is a member institution of
11 a rural health network of a State receiving a grant
12 under such subsection; and

13 “(3) a hospital or facility designated pursuant
14 to this subsection shall be eligible to receive a grant
15 under subsection (a)(2).”.

16 (B) CONFORMING AMENDMENTS.—(i) Sec-
17 tion 1820(c)(1) of such Act (42 U.S.C. 1395i-
18 4(c)(1)) is amended by striking “paragraph
19 (3)” and inserting “paragraph (3) or subsection
20 (k)”.

21 (ii) Paragraphs (1)(A) and (2)(A) of sec-
22 tion 1820(i) of such Act (42 U.S.C. 1395i-4(i))
23 are each amended—

1 (I) in clause (i), by striking “(a)(1)”
2 and inserting “(a)(1) (except as provided
3 in subsection (k))”, and

4 (II) in clause (ii), by striking “sub-
5 paragraph (B)” and inserting “subpara-
6 graph (B) or subsection (k)”.

7 (d) SKILLED NURSING SERVICES IN RURAL PRIMARY
8 CARE HOSPITALS.—Section 1820(f)(3) of the Social Secu-
9 rity Act (42 U.S.C. 1395i-4(f)(3)) is amended by striking
10 “because the facility” and all that follows and inserting
11 the following: “because, at the time the facility applies to
12 the State for designation as a rural primary care hospital,
13 there is in effect an agreement between the facility and
14 the Secretary under section 1883 under which the facili-
15 ty’s inpatient hospital facilities are used for the furnishing
16 of extended care services, except that the number of beds
17 used for the furnishing of such services may not exceed
18 the total number of licensed inpatient beds at the time
19 the facility applies to the State for such designation
20 (minus the number of inpatient beds used for providing
21 inpatient care pursuant to paragraph (1)(F)). For pur-
22 poses of the previous sentence, the number of beds of the
23 facility used for the furnishing of extended care services
24 shall not include any beds of a unit of the facility that
25 is licensed as a distinct-part skilled nursing facility at the

1 time the facility applies to the State for designation as
2 a rural primary care hospital.”.

3 (e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE
4 PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY
5 CARE HOSPITAL SERVICES.—Section 1814(l)(2) of the
6 Social Security Act (42 U.S.C. 1395f(l)(2)) is amended
7 by striking “January 1, 1993” and inserting “January 1,
8 1996”.

9 (f) PAYMENT FOR OUTPATIENT RURAL PRIMARY
10 CARE HOSPITAL SERVICES.—

11 (1) IMPLEMENTATION OF PROSPECTIVE PAY-
12 MENT SYSTEM.—Section 1834(g) of the Social Secu-
13 rity Act (42 U.S.C. 1395m(g)) is amended—

14 (A) in paragraph (1), by striking “during
15 a year before 1993” and inserting “during a
16 year before the prospective payment system de-
17 scribed in paragraph (2) is in effect”; and

18 (B) in paragraph (2), by striking “January
19 1, 1993,” and inserting “January 1, 1996,”.

20 (2) NO USE OF CUSTOMARY CHARGE IN DETER-
21 MINING PAYMENT.—Section 1834(g)(1) of such Act
22 (42 U.S.C. 1395m(g)(1)) is amended by adding at
23 the end the following new flush sentence:

1 “The amount of payment shall be determined under
 2 either method without regard to the amount of the
 3 customary or other charge.”.

4 (g) CLARIFICATION OF PHYSICIAN STAFFING RE-
 5 QUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—
 6 Section 1820(f)(1)(H) of the Social Security Act (42
 7 U.S.C. 1395i-4(f)(1)(H)) is amended by striking the pe-
 8 riod and inserting the following: “, except that in deter-
 9 mining whether a facility meets the requirements of this
 10 subparagraph, subparagraphs (E) and (F) of that para-
 11 graph shall be applied as if any reference to a ‘physician’
 12 is a reference to a physician as defined in section
 13 1861(r)(1).”.

14 (h) TECHNICAL AMENDMENTS RELATING TO PART
 15 A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILL-
 16 NESS.—(1) Section 1812(a)(1) of the Social Security Act
 17 (42 U.S.C. 1395d(a)(1)) is amended—

18 (A) by striking “inpatient hospital services” the
 19 first place it appears and inserting “inpatient hos-
 20 pital services or inpatient rural primary care hos-
 21 pital services”;

22 (B) by striking “inpatient hospital services” the
 23 second place it appears and inserting “such serv-
 24 ices”; and

1 (C) by striking “and inpatient rural primary
2 care hospital services”.

3 (2) Sections 1813(a) and 1813(b)(3)(A) of such Act
4 (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended
5 by striking “inpatient hospital services” each place it ap-
6 pears and inserting “inpatient hospital services or inpa-
7 tient rural primary care hospital services”.

8 (3) Section 1813(b)(3)(B) of such Act (42 U.S.C.
9 1395e(b)(3)(B)) is amended by striking “inpatient hos-
10 pital services” and inserting “inpatient hospital services,
11 inpatient rural primary care hospital services”.

12 (4) Section 1861(a) of such Act (42 U.S.C. 1395x(a))
13 is amended—

14 (A) in paragraph (1), by striking “inpatient
15 hospital services” and inserting “inpatient hospital
16 services, inpatient rural primary care hospital serv-
17 ices”; and

18 (B) in paragraph (2), by striking “hospital”
19 and inserting “hospital or rural primary care hos-
20 pital”.

21 (i) AUTHORIZATION OF APPROPRIATIONS.—Section
22 1820(e) of the Social Security Act (42 U.S.C. 1395i–4(e)),
23 as redesignated by subsection (c)(2)(A), is amended—

1 (1) in the matter preceding paragraph (1), by
2 striking “1990, 1991, and 1992” and inserting
3 “1990 through 1998”;

4 (2) in paragraph (1), by striking
5 “\$10,000,000” and “(a)(1)” and inserting
6 “\$30,000,000” and “(a)(2)(A)”, respectively; and

7 (3) in paragraph (2), by striking
8 “\$15,000,000” and “(a)(2)” and inserting
9 “\$45,000,000” and “(a)(2)(B)”, respectively.

10 (j) NO LIMITATION ON NUMBER OF RURAL PRIMARY
11 CARE HOSPITALS IN NON-EACH STATES.—Section
12 1820(i)(2)(C) of the Social Security Act (42 U.S.C.
13 1395i–4(i)(2)(C)) is amended—

14 (1) by striking “15”; and

15 (2) by striking “(f)(1), except that nothing”
16 and inserting “(f)(1) and establishes a relationship
17 with a full-service rural hospital that meets the re-
18 quirements described in paragraph (1) through (6)
19 of subsection (e), except that such hospital need not
20 meet the 75 bed requirement described in paragraph
21 (3) of such subsection. Nothing”.

22 (k) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect on the date of the enactment
24 of this Act.

1 **SEC. 352. DEMONSTRATION PROJECTS TO IMPROVE AC-**
2 **CESS IN RURAL AREAS.**

3 (a) IN GENERAL.—Part A of title XVIII of the Social
4 Security Act (42 U.S.C. 1395 et seq.) is amended by add-
5 ing at the end the following new section:

6 “DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN
7 RURAL AREAS

8 “SEC. 1821. (a) MEDICAL ASSISTANCE FACILITY
9 DEMONSTRATION PROJECT.—

10 (1) ESTABLISHMENT.—The Secretary shall pro-
11 vide for the establishment of demonstration projects
12 in States providing that medical assistance facilities
13 located in such States may receive payment in ac-
14 cordance with paragraph (4).

15 “(2) APPLICATIONS.—

16 “(A) IN GENERAL.—Each State desiring to
17 conduct a demonstrationproject under this sub-
18 section shall prepare and submit to the Sec-
19 retary an application, at such time, in such
20 manner, and containing such information as the
21 Secretary may require, including an explanation
22 of a plan for evaluating the project.

23 “(B) APPROVAL OF APPLICATIONS.—A
24 State that submits an application under sub-
25 paragraph (A) may begin a demonstration
26 project under this subsection—

1 “(i) upon approval of such application
2 by the Secretary; or

3 “(ii) at the end of the 60-day period
4 beginning on the date such application is
5 submitted, unless the Secretary denies the
6 application during such period.

7 “(3) MEDICAL ASSISTANCE FACILITY.—The
8 term ‘medical assistance facility’ means for a fiscal
9 year, a facility with respect to which the Secretary
10 finds the following:

11 “(A) The facility is located in a county (or
12 equivalent unit of local government) with fewer
13 than 6 residents per square mile or is located
14 more than a 35 mile drive from a hospital, a
15 rural primary care hospital, or another facility
16 described in this subsection.

17 “(B) The facility furnishes services to ill or
18 injured individuals prior to the transportation
19 of such individuals to a hospital or furnishes in-
20 patient care to individuals needing such care for
21 a period not longer than 96 hours.

22 “(C) The facility permits a physician as-
23 sistant or nurse practitioner to admit and treat
24 patients under the supervision of a physician
25 not present in such facility.

1 “(D) The facility meets the requirements
2 of section 1861(e) that are applicable to a hos-
3 pital located in a rural area except that—

4 “(i) with respect to any requirements
5 relating to the number of hours that the
6 facility must be open on a daily or weekly
7 basis, the facility is only required to meet
8 the requirement to provide emergency care
9 on a 24-hour basis;

10 “(ii) with respect to any services re-
11 quired under such section to be furnished
12 by a dietician, pharmacist, laboratory tech-
13 nician, medical technologist, and radiologi-
14 cal technologist, the facility may furnish
15 such services on a part-time, off-site basis;
16 and

17 “(iii) the inpatient care described in
18 subparagraph (B) may be furnished by a
19 physician assistant or nurse practitioner as
20 provided in subparagraph (C).

21 “(E) The facility receives a certification of
22 medical necessity and appropriateness by a peer
23 review organization (or the equivalent of a peer
24 review organization) upon admitting each pa-
25 tient on an inpatient basis or, in the case of ad-

1 missions that do not occur during regular busi-
2 ness hours, receives such a certification at the
3 earliest possible time.

4 “(F) The facility may enter into an agree-
5 ment with the Secretary under section 1883
6 under which the facility’s inpatient hospital fa-
7 cilities may be used for the furnishing of serv-
8 ices of the type which, if furnished by a skilled
9 nursing facility, would constitute extended care
10 services.

11 “(4) PAYMENT FOR SERVICES.—Each medical
12 assistance facility located in a State participating in
13 a demonstration project under this subsection shall
14 receive payment for inpatient medical assistance fa-
15 cility services (as defined in section 1861(oo)(2)) in
16 accordance with section 1814(m) and outpatient
17 medical assistance facility services (as defined in sec-
18 tion 1861(oo)(3)) in accordance with section
19 1834(i).

20 “(5) GRANTS.—The Secretary shall award
21 grants to—

22 “(A) selected States participating in a
23 demonstration project under this subsection for
24 the purpose of assisting such States in promot-

1 ing the establishment of medical assistance fa-
2 cilities; and

3 “(B) selected facilities in States participat-
4 ing in a demonstration project under this sec-
5 tion for the purpose of financing the costs a fa-
6 cility incurs in converting itself to a medical as-
7 sistance facility.

8 “(6) MAINTENANCE OF EFFORT.—Any funds
9 available for the activities covered by a demonstra-
10 tion project conducted under this subsection shall
11 supplement, and shall not supplant, funds that are
12 expended for similar purposes under any State, re-
13 gional, or local program.

14 “(7) DURATION.—A demonstration project
15 under this subsection shall be conducted for a period
16 not to exceed 8 years.

17 “(8) EVALUATIONS AND REPORTS.—

18 “(A) EVALUATIONS.—Each State that con-
19 ducts a demonstration project under this sub-
20 section shall submit to the Secretary a final
21 evaluation of such project within 360 days of
22 the termination of such project and such in-
23 terim evaluations as the Secretary may require.

24 “(B) REPORTS TO CONGRESS.—Not later
25 than 360 days after the first demonstration

1 project under this subsection begins, and annu-
2 ally thereafter for each year in which a project
3 is conducted under this subsection, the Sec-
4 retary shall submit a report to the appropriate
5 committees of the Congress which evaluates the
6 effectiveness of the demonstration projects con-
7 ducted under this subsection and includes any
8 legislative recommendations determined appro-
9 priate by the Secretary.

10 “(9) AUTHORIZATION OF APPROPRIATIONS.—

11 There are authorized to be appropriated for each of
12 the fiscal years 1995 through 2000 from the Federal
13 Hospital Insurance Trust Fund—

14 “(A) \$20,000,000 for grants to States
15 under paragraph (5)(A); and

16 “(B) \$20,000,000 for grants to facilities
17 under paragraph (5)(B).

18 “(b) RURAL EMERGENCY ACCESS CARE HOSPITAL
19 DEMONSTRATION PROJECT.—

20 “(1) IN GENERAL.—

21 “(A) ESTABLISHMENT.—The Secretary
22 shall provide for the establishment of dem-
23 onstration projects in States providing that
24 rural emergency access care hospitals located in
25 such States may receive payment in accordance

1 with paragraph (5) for rural emergency access
2 care hospital services provided to medicare
3 beneficiaries.

4 “(2) APPLICATIONS.—

5 “(A) IN GENERAL.—Each State desiring to
6 conduct a demonstration project under this sub-
7 section shall prepare and submit to the Sec-
8 retary an application, at such time, in such
9 manner, and containing such information as the
10 Secretary may require, including an explanation
11 of a plan for evaluating the project.

12 “(B) APPROVAL OF APPLICATIONS.—A
13 State that submits an application under sub-
14 paragraph (A) may begin a demonstration
15 project under this subsection—

16 “(i) upon approval of such application
17 by the Secretary; or

18 “(ii) at the end of the 60-day period
19 beginning on the date such application is
20 submitted, unless the Secretary denies the
21 application during such period.

22 “(3) RURAL EMERGENCY ACCESS CARE HOS-
23 PITAL.—For purposes of this subsection, the term
24 ‘rural emergency access care hospital’ means, for a

1 fiscal year, a facility with respect to which the Sec-
2 retary finds the following:

3 “(A) The facility is located in a rural area
4 (as defined in section 1886(d)(2)(D)).

5 “(B) The facility was a hospital under this
6 title at any time during the 5-year period that
7 ends on the date of the enactment of this sub-
8 section.

9 “(C) The facility is in danger of closing
10 due to low inpatient utilization rates and nega-
11 tive operating losses, and the closure of the fa-
12 cility would limit the access of individuals resid-
13 ing in the facility’s service area to emergency
14 services.

15 “(D) The facility has entered into (or
16 plans to enter into) an agreement with a hos-
17 pital with a participation agreement in effect
18 under section 1866(a), and under such agree-
19 ment the hospital shall accept patients trans-
20 ferred to the hospital from the facility and re-
21 ceive data from and transmit data to the facil-
22 ity.

23 “(E) There is a practitioner who is quali-
24 fied to provide advanced cardiac life support
25 services (as determined by the State in which

1 the facility is located) on-site at the facility on
2 a 24-hour basis.

3 “(F) A physician is available on-call to
4 provide emergency medical services on a 24-
5 hour basis.

6 “(G) The facility meets such staffing re-
7 quirements as would apply under section
8 1861(e) to a hospital located in a rural area,
9 except that—

10 “(i) the facility need not meet hospital
11 standards relating to the number of hours
12 during a day, or days during a week, in
13 which the facility must be open, except in-
14 sofar as the facility is required to provide
15 emergency care on a 24-hour basis under
16 subparagraphs (E) and (F); and

17 “(ii) the facility may provide any serv-
18 ices otherwise required to be provided by a
19 full-time, on-site dietician, pharmacist, lab-
20 oratory technician, medical technologist, or
21 radiological technologist on a part-time,
22 off-site basis.

23 “(H) The facility meets the requirements
24 applicable to clinics and facilities under sub-
25 paragraphs (C) through (J) of paragraph (2) of

1 section 1861(aa) and of clauses (ii) and (iv) of
2 the second sentence of such paragraph (or, in
3 the case of the requirements of subparagraph
4 (E), (F), or (J) of such paragraph, would meet
5 the requirements if any reference in such sub-
6 paragraph to a ‘nurse practitioner’ or to ‘nurse
7 practitioners’ was deemed to be a reference to
8 a ‘nurse practitioner or nurse’ or to ‘nurse
9 practitioners or nurses’), except that in deter-
10 mining whether a facility meets the require-
11 ments of this subparagraph, subparagraphs (E)
12 and (F) of that paragraph shall be applied as
13 if any reference to a ‘physician’ is a reference
14 to a physician as defined in section 1861(r)(1).

15 “(4) RURAL EMERGENCY ACCESS CARE HOS-
16 PITAL SERVICES.—For purposes of this subsection,
17 the term ‘rural emergency access care hospital serv-
18 ices’ means the following services provided by a rural
19 emergency access care hospital:

20 “(A) An appropriate medical screening ex-
21 amination (as described in section 1867(a)).

22 “(B) Necessary stabilizing examination
23 and treatment services for an emergency medi-
24 cal condition and labor (as described in section
25 1867(b)).”.

1 “(5) PAYMENT FOR SERVICES.—Each rural
2 emergency access care hospital located in a State
3 participating in a demonstration project under this
4 subsection shall receive payment for rural emergency
5 access care hospital services in accordance with sec-
6 tion 1833(a)(6).

7 “(6) GRANTS.—The Secretary shall award
8 grants to—

9 “(A) selected States participating in a
10 demonstration project under this subsection for
11 the purpose of assisting such States in promot-
12 ing the establishment of rural emergency access
13 care hospitals; and

14 “(B) selected facilities in States participat-
15 ing in a demonstration project under this sec-
16 tion for the purpose of financing the costs a fa-
17 cility incurs in converting itself to a rural emer-
18 gency access care hospitals.

19 “(7) MAINTENANCE OF EFFORT.—Any funds
20 available for the activities covered by a demonstra-
21 tion project conducted under this subsection shall
22 supplement, and shall not supplant, funds that are
23 expended for similar purposes under any State, re-
24 gional, or local program.

1 “(8) DURATION.—A demonstration project
2 under this subsection shall be conducted for a period
3 not to exceed 8 years.

4 “(9) EVALUATIONS AND REPORTS.—

5 “(A) EVALUATIONS.—Each State that con-
6 ducts a demonstration project under this sub-
7 section shall submit to the Secretary a final
8 evaluation of such project within 360 days of
9 the termination of such project and such in-
10 terim evaluations as the Secretary may require.

11 “(B) REPORTS TO CONGRESS.—Not later
12 than 360 days after the first demonstration
13 project under this subsection begins, and annu-
14 ally thereafter for each year in which a project
15 is conducted under this subsection, the Sec-
16 retary shall submit a report to the appropriate
17 committees of the Congress which evaluates the
18 effectiveness of the demonstration projects con-
19 ducted under this subsection and includes any
20 legislative recommendations determined appro-
21 priate by the Secretary.

22 “(10) AUTHORIZATION OF APPROPRIATIONS.—

23 There are authorized to be appropriated for each of
24 the fiscal years 1995 through 2000 from the Federal
25 Hospital Insurance Trust Fund—

7 (1) AMENDMENTS TO PART A.—

12 “Medical Assistance Facility; Medical Assistance Facility
13 Services

(2) The term ‘inpatient medical assistance facility services’ means items and services furnished to an inpatient of a medical assistance facility by such facility that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.”.

1 (B) COVERAGE AND PAYMENT.—(i) Sec-
2 tion 1812(a)(1) of such Act (42 U.S.C.
3 1395d(a)(1)) is amended by striking “and inpa-
4 tient rural primary care hospital services” and
5 inserting “, inpatient rural primary care hos-
6 pital services, and inpatient medical assistance
7 facility services”.

8 (ii) Section 1814 of such Act (42 U.S.C.
9 1395f) is amended—

10 (I) in subsection (a)—

11 (aa) by striking “and” at the end
12 of paragraph (7),

13 (bb) by striking the period at the
14 end of paragraph (8) and inserting “;
15 and”, and

16 (cc) by inserting after paragraph
17 (8) the following new paragraph:

18 “(9) in the case of inpatient medical assistance
19 facility services, a physician certifies that such serv-
20 ices were required to be immediately furnished on a
21 temporary, inpatient basis.”;

22 (ii) in subsection (b), by striking “inpa-
23 tient rural primary care hospital services,” and
24 inserting “inpatient rural primary care hospital
25 services, other than a medical assistance facility

1 providing inpatient medical assistance facility
2 services,”; and

3 (III) by adding at the end the follow-
4 ing new subsection:

5 “Payment for Inpatient Medical Assistance Facility
6 Services

7 “(m) The amount of payment under this part for in-
8 patient medical assistance facility services is the reason-
9 able costs of the medical assistance facility in providing
10 such services.”.

11 (C) TREATMENT OF MEDICAL ASSISTANCE
12 FACILITIES AS PROVIDERS OF SERVICES.—(i)
13 Section 1861(u) of such Act (42 U.S.C.
14 1395x(u)) is amended by inserting “medical as-
15 sistance facility,” after “rural primary care hos-
16 pital,”.

17 (ii) The first sentence of section 1864(a) of
18 such Act (42 U.S.C. 1395aa(a)) is amended by
19 inserting “a medical assistance facility, as de-
20 fined in section 1861(oo)(1),” after
21 “1861(mm)(1),”.

22 (iii) The third sentence of section 1865(a)
23 of such Act (42 U.S.C. 1395bb(a)) is amended
24 by striking “or 1861(mm)(1)” and inserting
25 “1861(mm)(1), or 1861(oo)(1),”.

1 (D) CONFORMING AMENDMENTS.—(i) Sec-
2 tion 1128A(b)(1) of such Act (42 U.S.C.
3 1320a–7a(b)(1)) is amended—

4 (I) by striking “or a rural primary
5 care hospital” the first place it appears
6 and inserting “, a rural primary care hos-
7 pital, or a medical assistance facility”; and

8 (II) by striking “or a rural primary
9 care hospital” the second place it appears
10 and inserting “, the rural primary care
11 hospital, or the medical assistance facil-
12 ity”.

13 (ii) Section 1128B(c) of such Act (42
14 U.S.C. 1320a–7b(c)) is amended by inserting
15 “medical assistance facility,” after “rural pri-
16 mary care hospital,”.

17 (iii) Section 1134 of such Act (42 U.S.C.
18 1320b–4) is amended by striking “or rural pri-
19 mary care hospitals” each place it appears and
20 inserting “, rural primary care hospitals, or
21 medical assistance facilities”.

22 (iv) Section 1138(a)(1) of such Act (42
23 U.S.C. 1320b–8(a)(1)) is amended—

24 (I) in the matter preceding subpara-
25 graph (A), by striking “or rural primary

1 care hospital” and inserting “, rural pri-
2 mary care hospital, or medical assistance
3 facility”, and

4 (II) in the matter preceding clause (i)
5 of subparagraph (A), by striking “or rural
6 primary care hospital” and inserting “,
7 rural primary care hospital, or medical as-
8 sistance facility”.

9 (v) Section 1164(e) of such Act (42 U.S.C.
10 1320c-13(e)) is amended by inserting “medical
11 assistance facilities,” after “rural primary care
12 hospitals,”.

13 (vi) Section 1816(c)(2)(C) of such Act (42
14 U.S.C. 1395h(c)(2)(C)) is amended by inserting
15 “medical assistance facility,” after “rural pri-
16 mary care hospital,”.

17 (vii) Section 1833 of such Act (42 U.S.C.
18 1395l) is amended—

19 (I) in subsection (h)(5)(A)(iii)—

20 (aa) by striking “or rural pri-
21 mary care hospital” and inserting
22 “rural primary care hospital, or medi-
23 cal assistance facility”; and

1 (bb) by striking “to the hospital”
2 and inserting “to the hospital or the
3 facility”;

4 (II) in subsection (i)(1)(A), by insert-
5 ing “medical assistance facility,” after
6 “rural primary care hospital,”;

7 (III) in subsection (i)(3)(A), by strik-
8 ing “or rural primary care hospital serv-
9 ices” and inserting “rural primary care
10 hospital services, or medical assistance fa-
11 cility services”;

12 (IV) in subsection (l)(5)(A), by insert-
13 ing “medical assistance facility,” after
14 “rural primary care hospital,” each place it
15 appears; and

16 (V) in subsection (l)(5)(C), by striking
17 “or rural primary care hospital” each place
18 it appears and inserting “, rural primary
19 care hospital, or medical assistance facil-
20 ity”.

21 (viii) Section 1835(c) of such Act (42
22 U.S.C. 1395n(c)) is amended by adding at the
23 end the following: “A medical assistance facility
24 shall be considered a hospital for purposes of
25 this subsection.”.

1 (ix) Section 1842(b)(6)(A)(ii) of such Act
2 (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by
3 inserting “medical assistance facility,” after
4 “rural primary care hospital,”.

5 (x) Section 1861 of such Act (42 U.S.C.
6 1395x) is amended—

7 (I) in the last sentence of subsection
8 (e), by striking “1861(mm)(1))” and in-
9 serting “1861(mm)(1)) or a medical assist-
10 ance facility (as defined in section
11 1861(oo)(1)).”,

12 (II) in subsection (w)(1) by inserting
13 “medical assistance facility,” after “rural
14 primary care hospital,”, and

15 (III) in subsection (w)(2), by striking
16 “or rural primary care hospital” each place
17 it appears and inserting “, rural primary
18 care hospital, or medical assistance facil-
19 ity”.

20 (xi) Section 1862(a)(14) of such Act (42
21 U.S.C. 1395y(a)(14)) is amended by striking
22 “or rural primary care hospital” each place it
23 appears and inserting “, rural primary care
24 hospital, or medical assistance facility”.

1 (xii) Section 1866(a)(1) of such Act (42
2 U.S.C 1395cc(a)(1)) is amended—

3 (I) in subparagraph (F)(ii), by insert-
4 ing “medical assistance facilities,” after
5 “rural primary care hospitals,”;

6 (II) in subparagraph (H)—

7 (aa) in the matter preceding
8 clause (i), by inserting “and in the
9 case of medical assistance facilities
10 which provide inpatient medical assist-
11 ance facility services” after “rural pri-
12 mary care hospital services”; and

13 (bb) in clauses (i) and (ii), by
14 striking “hospital” each place it ap-
15 pears and inserting “hospital or facil-
16 ity”;

17 (III) in subparagraph (I)—

18 (aa) in the matter preceding
19 clause (i), by striking “or rural pri-
20 mary care hospital” and inserting “, a
21 rural primary care hospital, or a med-
22 ical assistance facility”; and

23 (bb) in clause (ii), by striking
24 “the hospital” and inserting “the hos-
25 pital or the facility”; and

1 (IV) in subparagraph (N)—

2 (aa) in the matter preceding
3 clause (i), by striking “and rural pri-
4 mary hospitals” and inserting “, rural
5 primary care hospitals, and medical
6 assistance facilities”;

7 (bb) in clause (i), by striking “or
8 rural primary care hospital,” and in-
9 serting “, rural primary care hospital,
10 or medical assistance facility,”; and

11 (cc) in clause (ii), by striking
12 “hospital” and inserting “hospital or
13 facility”.

14 (xiii) Section 1866(a)(3) of such Act (42
15 U.S.C 1395cc(a)(3)) is amended—

16 (I) by striking “rural primary care
17 hospital,” each place it appears in sub-
18 paragraphs (A) and (B) and inserting
19 “rural primary care hospital, medical as-
20 sistance facility,”, and

21 (II) in subparagraph (C)(ii)(II), by
22 striking “rural primary care hospitals,”
23 each place it appears and inserting “rural
24 primary care hospitals, medical assistance
25 facilities”.

1 (xiv) Section 1867(e)(5) of such Act (42
2 U.S.C. 1395dd(e)(5)) is amended by striking
3 “1861(mm)(1))” and inserting “1861(mm)(1))
4 or a medical assistance facility (as defined in
5 section 1861(oo)(1)).”.

6 (2) AMENDMENTS TO PART B.—

7 (A) COVERAGE.—(i) Section 1861(oo) of
8 the Social Security Act (42 U.S.C. 1395x(oo)),
9 as added by paragraph (1)(A), is amended by
10 adding at the end the following new paragraph:

11 “(3) The term ‘outpatient medical assistance facility
12 services’ means medical and other health services fur-
13 nished by a medical assistance facility on an outpatient
14 basis.”.

15 (ii) Section 1832(a)(2) of such Act (42
16 U.S.C. 1395k(a)(2)) is amended—

17 (I) in subparagraph (I), by striking
18 “and” at the end;

19 (II) in subparagraph (J), by striking
20 the period at the end and inserting “;
21 and”; and

22 (III) by adding at the end the follow-
23 ing new subparagraph:

24 “(K) outpatient medical assistance facility
25 services (as defined in section 1861(oo)(3)).”.

1 (B) PAYMENT.—(i) Section 1833(a) of
2 such Act (42 U.S.C. 1395l(a)) is amended—

3 (I) in paragraph (2), in the matter
4 preceding subparagraph (A), by striking
5 “and (I)” and inserting “(I), and (K)”;

6 (II) in paragraph (6), by striking
7 “and” at the end;

8 (III) in paragraph (7), by striking the
9 period at the end and inserting “; and”;
10 and

11 (IV) by adding at the end the follow-
12 ing new paragraph:

13 “(8) in the case of outpatient medical assist-
14 ance facility services, the amounts described in sec-
15 tion 1834(i).”.

16 (ii) Section 1834 of such Act (42 U.S.C.
17 1395m) is amended by adding at the end the
18 following new subsection:

19 “(i) PAYMENT FOR OUTPATIENT MEDICAL ASSIST-
20 ANCE FACILITY SERVICES.—The amount of payment for
21 outpatient medical assistance facility services provided in
22 a medical assistance facility under this part shall be deter-
23 mined by one of the two following methods, as elected by
24 the medical assistance facility:

1 “(1) COST-BASED FACILITY FEE PLUS PROFES-
2 SIONAL CHARGES.—

3 “(A) FACILITY FEE.—With respect to fa-
4 cility services, not including any services for
5 which payment may be made under subpara-
6 graph (B), there shall be paid amounts equal to
7 the amounts described in section 1833(a)(2)(B)
8 (describing amounts paid for hospital out-
9 patient services).

10 “(B) REASONABLE CHARGES FOR PROFES-
11 SIONAL SERVICES.—In electing treatment under
12 this paragraph, payment for professional medi-
13 cal services otherwise included within outpatient
14 medical assistance facility services shall be
15 made under such other provisions of this part
16 as would apply to payment for such services if
17 they were not included in outpatient medical as-
18 sistance facility services.

19 “(2) ALL-INCLUSIVE RATE.—

20 “(A) IN GENERAL.—With respect to both
21 facility services and professional medical serv-
22 ices, there shall be paid amounts equal to the
23 excess of—

24 “(i) the costs which are reasonable
25 and related to the cost of furnishing such

1 services or which are based on such other
2 tests of reasonableness as the Secretary
3 may prescribe in regulations, over

4 “(ii) the amount the facility may
5 charge as described in clause (i) of section
6 1866(a)(2)(A).

7 “(B) LIMITATION.—

8 “(i) IN GENERAL.—The payment
9 amount determined under subparagraph
10 (A) with respect to items and services shall
11 not exceed 80 percent of the amount deter-
12 mined under clause (i) of such subpara-
13 graph with respect to such items and serv-
14 ices.

15 “(ii) CERTAIN ITEMS AND SERV-
16 ICES.—Clause (i) shall not apply to—

17 “(I) items and services described
18 in section 1861(s)(10)(A), and

19 “(II) items and services fur-
20 nished in connection with obtaining a
21 second opinion required under section
22 1164(c)(2), or third opinion, if the
23 second opinion was in disagreement
24 with the first opinion.”.

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall be effective for services pro-
3 vided on or after the October 1, 1995.

4 (c) RURAL EMERGENCY ACCESS CARE HOSPITALS.—

5 (1) RURAL EMERGENCY ACCESS CARE HOS-
6 PITALS DESCRIBED.—Section 1861 of the Social Se-
7 curity Act (42 U.S.C. 1395x) is amended by adding
8 at the end the following new subsection:

9 “Rural Emergency Access Care Hospital; Rural
10 Emergency Access Care Hospital Services
11 “(pp)(1) The term ‘rural emergency access care hos-
12 pital’ means, for a fiscal year, a facility in a State partici-
13 pating in a demonstration project under section 1820(b)
14 and that meets the criteria described in subparagraphs (A)
15 through (H) of section 1820(b)(3).

16 “(2) The term ‘rural emergency access care hospital
17 services’ means the following services provided by a rural
18 emergency access care hospital:

19 “(A) An appropriate medical screening exam-
20 ination (as described in section 1867(a)).

21 “(B) Necessary stabilizing examination and
22 treatment services for an emergency medical condi-
23 tion and labor (as described in section 1867(b)).”.

24 (2) REQUIRING RURAL EMERGENCY ACCESS
25 CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING

1 REQUIREMENTS.—Section 1867(e)(5) of such Act
 2 (42 U.S.C. 1395(e)(5)) is amended by striking
 3 “1861(mm)(1)” and inserting “1861(mm)(1)) and a
 4 rural emergency access care hospital (as defined in
 5 section 1861(pp)(1))”.

6 (3) COVERAGE OF AND PAYMENT FOR SERV-
 7 ICES.—Section 1832(a)(2) of the Social Security Act
 8 (42 U.S.C. 1395k(a)(2)), as amended in subsection
 9 (b)(2)(A)(ii), is amended—

10 (A) by striking “and” at the end of sub-
 11 paragraph (J);

12 (B) by striking the period at the end of
 13 subparagraph (K) and inserting “; and”; and

14 (C) by adding at the end the following new
 15 subparagraph:

16 “(L) rural emergency access care hospital
 17 services (as defined in section 1861(pp)(2)).”

18 (4) PAYMENT BASED ON PAYMENT FOR OUT-
 19 PATIENT RURAL PRIMARY CARE HOSPITAL SERV-
 20 ICES.—

21 (A) IN GENERAL.—Section 1833(a)(6) of
 22 the Social Security Act (42 U.S.C. 1395l(a)(6))
 23 is amended by striking “services,” and inserting
 24 “services and rural emergency access care hos-
 25 pital services,”.

1 (B) PAYMENT METHODOLOGY DE-
 2 SCRIBED.—Section 1834(g) of such Act (42
 3 U.S.C. 1395m(g)) is amended—

4 (i) in the heading, by striking “SERV-
 5 ICES” and inserting “SERVICES AND
 6 RURAL EMERGENCY ACCESS CARE HOS-
 7 PITAL SERVICES”; and

8 (ii) by adding at the end the following
 9 new paragraph:

10 “(3) APPLICATION OF METHODS TO PAYMENT
 11 FOR RURAL EMERGENCY ACCESS CARE HOSPITAL
 12 SERVICES.—The amount of payment for rural emer-
 13 gency access care hospital services provided during
 14 a year shall be determined using the applicable
 15 method provided under this subsection for determin-
 16 ing payment for outpatient rural primary care hos-
 17 pital services during the year.”.

18 (5) EFFECTIVE DATE.—The amendments made
 19 by this subsection shall be effective for services pro-
 20 vided on or after the October 1, 1995.

21 **SEC. 353. MEDICARE-DEPENDENT, SMALL RURAL HOS-**
 22 **PITALS.**

23 (a) CLARIFICATION OF ADDITIONAL PAYMENT.—
 24 Section 1886(d)(5)(G)(ii)(I) of the Social Security Act (42
 25 U.S.C. 1395ww(d)(5)(G)(ii)(I)) is amended by striking

1 “the first 3 12-month cost reporting periods that begin”
2 and inserting “the 36-month period beginning with the
3 first day of the cost reporting period that begins”.

4 (b) SPECIAL TREATMENT EXTENDED.—Section
5 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G))
6 is amended—

7 (1) in clause (i), by striking “October 1, 1994”
8 and inserting “October 1, 1999”; and

9 (2) in clause (ii)(II), by striking “October 1,
10 1994” and inserting “October 1, 1999”.

11 (c) EXTENSION OF TARGET AMOUNT.—Section
12 1886(b)(3)(D) of such Act (42 U.S.C. 1395ww(b)(3)(D))
13 is amended—

14 (1) in the matter preceding clause (i), by strik-
15 ing “March 31, 1993” and inserting “September 30,
16 1999”; and

17 (2) by amending clause (iii) to read as follows:

18 “(iii) with respect to discharges occurring in fis-
19 cal years 1994 through 1999, the target amount for
20 the cost reporting period beginning in the previous
21 fiscal year increased by the applicable percentage in-
22 crease under subparagraph (B)(iv).”.

1 **SEC. 354. EXPANDED COVERAGE FOR PHYSICIAN ASSIST-**
 2 **ANTS AND NURSE PRACTITIONERS.**

3 (a) COVERAGE IN OUTPATIENT SETTINGS.—(1) Sec-
 4 tion 1861(s)(2)(K) of the Social Security Act (42 U.S.C.
 5 1395x(s)(2)(K)) is amended—

6 (A) in clause (i)—

7 (i) by striking “or” at the end of
 8 subclause (II); and

9 (ii) by inserting “or (IV) in an out-
 10 patient setting as defined by the Sec-
 11 retary” following “shortage area,”; and

12 (B) in clause (ii), by striking “in a skilled
 13 nursing facility or nursing facility (as defined in
 14 section 1919(a))” and inserting “(I) in a skilled
 15 nursing facility or nursing facility (as defined in
 16 section 1919(a)), or (II) in an outpatient set-
 17 ting as defined by the Secretary”.

18 (2) Section 1833(r)(1) of such Act (42 U.S.C.
 19 1395l(r)(1)) is amended by striking “rural area)”
 20 and inserting “rural area), or for services described
 21 in section 1861(s)(2)(K)(ii)(II) (relating to nurse
 22 practitioner services in an outpatient settings)”.

23 (3) Section 1842(b)(6)(C) (42 U.S.C.
 24 1395u(b)(6)(C)) is amended by striking “(ii)” and
 25 inserting “(ii)(II)”.

1 (b) PAYMENT BASED ON PHYSICIAN FEE SCHED-
2 ULE.—

3 (1) Section 1833(a)(1)(O) of such Act (42
4 U.S.C. 1395l(a)(1)(O)) is amended—

5 (A) by striking “section 1861(s)(2)(K)(iii)
6 (relating to nurse practitioner and clinical nurse
7 specialist services provided in a rural area)”
8 and inserting “section 1861(s)(2)(K)”;

9 (B) by striking “for services furnished on
10 or after January 1, 1992,” and inserting “for
11 services described in section 1861(s)(2)(K)(iii)
12 furnished on or after January 1, 1992, and for
13 services described in clauses (i), (ii), and (iv) of
14 section 1861(s)(2)(K) furnished on or after
15 January 1, 1997,”; and

16 (C) by striking “subsection (r)(2)” and in-
17 serting “subsection (r)(2) or subparagraph (A)
18 or (B) of section 1842(b)(12)”.

19 (2) Section 1842(b)(12)(A) of such Act (42
20 U.S.C. 1395u(b)(12)(A)) is amended—

21 (A) by striking “and” at the end of clause
22 (i);

23 (B) in clause (ii) in the matter preceding
24 subclause (I), by striking “the prevailing” and

1 inserting “for services furnished before January
2 1, 1997, the prevailing”;

3 (C) by striking the period at the end of
4 clause (ii)(II) and inserting “; and”; and

5 (D) by inserting at the end the following
6 clause:

7 “(iii) in the case of services furnished
8 on or after January 1, 1997, the fee sched-
9 ule amount shall be equal to—

10 “(I) in the case of services per-
11 formed as an assistant at surgery, 65
12 percent of the amount that would oth-
13 erwise be recognized if performed by a
14 physician who is serving as an assist-
15 ance at surgery,

16 “(II) in the case of services per-
17 formed (other than as an assistant at
18 surgery) in a hospital, 75 percent of
19 the fee schedule amount specified
20 under section 1848, and

21 “(III) in the case of other serv-
22 ices, 85 percent of the fee schedule
23 amount specified under section 1848.

24 (c) RURAL NURSE PRACTITIONERS AS ASSISTANTS
25 AT SURGERY IN URBAN AREAS.—Section

1 1861(s)(2)(K)(ii) of such Act (42 U.S.C.
2 1395x(s)(2)(K)(ii)), as amended by subsection (a)(2), is
3 further amended by adding “or services as an assistant
4 at surgery furnished by a nurse practitioner whose pri-
5 mary practice location (as defined by the Secretary) is in
6 a rural area (as defined in section 1886(d)(2)(D)) to an
7 individual who resides in a rural area when the service
8 is furnished to such individual in an urban area by such
9 practitioner when such practitioner refers such individual
10 to an urban area for the furnishing of services” after “as
11 defined by the Secretary”.

12 (d) CONFORMING AMENDMENTS.—

13 (1) Section 1861(b)(4) of such Act (42 U.S.C.
14 1395x(b)(4)) is amended by striking “subsection
15 (s)(2)(K)(i)” and inserting “subsection (s)(2)(K)”.

16 (2) Section 1862(a)(14) of such Act (42 U.S.C.
17 1395y(a)(14)), as amended by section 620(b)(4)(K),
18 is amended by striking “section 1861(s)(2)(K)(i)”
19 and inserting “section 1861(s)(2)(K)”.

20 (3) Section 1866(a)(1)(H) of such Act (42
21 U.S.C. 1395cc(a)(1)(H)), is amended by striking
22 “section 1861(s)(2)(K)(i)” and inserting “section
23 1861(s)(2)(K)”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 1997.

4 **Subtitle F—Emergency Medical**
5 **Systems**

6 **SEC. 361. GRANTS TO STATES REGARDING AIRCRAFT FOR**
7 **TRANSPORTING RURAL VICTIMS OF MEDICAL**
8 **EMERGENCIES.**

9 Part E of title XII of the Public Health Service Act
10 (42 U.S.C. 300d–51 et seq.) is amended by adding at the
11 end thereof the following new section:

12 **“SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL**
13 **VICTIMS OF MEDICAL EMERGENCIES.**

14 “(a) IN GENERAL.—The Secretary shall make grants
15 to States to assist such States in the creation or enhance-
16 ment of air medical transport systems that provide victims
17 of medical emergencies in rural areas with access to treat-
18 ments for the injuries or other conditions resulting from
19 such emergencies.

20 “(b) APPLICATION AND PLAN.—

21 “(1) APPLICATION.—To be eligible to receive a
22 grant under subsection (a), a State shall prepare
23 and submit to the Secretary an application in such
24 form, made in such manner, and containing such
25 agreements, assurances, and information, including

1 a State plan as required in paragraph (2), as the
2 Secretary determines to be necessary to carry out
3 this section.

4 “(2) STATE PLAN.—An application submitted
5 under paragraph (1) shall contain a State plan that
6 shall—

7 “(A) describe the intended uses of the
8 grant proceeds and the geographic areas to be
9 served;

10 “(B) demonstrate that the geographic
11 areas to be served, as described under subpara-
12 graph (A), are rural in nature;

13 “(C) demonstrate that there is a lack of
14 facilities available and equipped to deliver ad-
15 vanced levels of medical care in the geographic
16 areas to be served;

17 “(D) demonstrate that in utilizing the
18 grant proceeds for the establishment or en-
19 hancement of air medical services the State
20 would be making a cost-effective improvement
21 to existing ground-based or air emergency medi-
22 cal service systems;

23 “(E) demonstrate that the State will not
24 utilize the grant proceeds to duplicate the capa-
25 bilities of existing air medical systems that are

1 effectively meeting the emergency medical needs
2 of the populations they serve;

3 “(F) demonstrate that in utilizing the
4 grant proceeds the State is likely to achieve a
5 reduction in the morbidity and mortality rates
6 of the areas to be served, as determined by the
7 Secretary;

8 “(G) demonstrate that the State, in utiliz-
9 ing the grant proceeds, will—

10 “(i) maintain the expenditures of the
11 State for air and ground medical transport
12 systems at a level equal to not less than
13 the level of such expenditures maintained
14 by the State for the fiscal year preceding
15 the fiscal year for which the grant is re-
16 ceived; and

17 “(ii) ensure that recipients of direct
18 financial assistance from the State under
19 such grant will maintain expenditures of
20 such recipients for such systems at a level
21 at least equal to the level of such expendi-
22 tures maintained by such recipients for the
23 fiscal year preceding the fiscal year for
24 which the financial assistance is received;

1 “(H) demonstrate that persons experienced
2 in the field of air medical service delivery were
3 consulted in the preparation of the State plan;
4 and

5 “(I) contain such other information as the
6 Secretary may determine appropriate.

7 “(c) CONSIDERATIONS IN AWARDING GRANTS.—In
8 determining whether to award a grant to a State under
9 this section, the Secretary shall—

10 “(1) consider the rural nature of the areas to
11 be served with the grant proceeds and the services
12 to be provided with such proceeds, as identified in
13 the State plan submitted under subsection (b); and

14 “(2) give preference to States with State plans
15 that demonstrate an effective integration of the pro-
16 posed air medical transport systems into a com-
17 prehensive network or plan for regional or statewide
18 emergency medical service delivery.

19 “(d) STATE ADMINISTRATION AND USE OF
20 GRANT.—

21 “(1) IN GENERAL.—The Secretary may not
22 make a grant to a State under subsection (a) unless
23 the State agrees that such grant will be adminis-
24 tered by the State agency with principal responsibil-
25 ity for carrying out programs regarding the provi-

1 sion of medical services to victims of medical emer-
2 gencies or trauma.

3 “(2) PERMITTED USES.—A State may use
4 amounts received under a grant awarded under this
5 section to award subgrants to public and private en-
6 tities operating within the State.

7 “(3) OPPORTUNITY FOR PUBLIC COMMENT.—
8 The Secretary may not make a grant to a State
9 under subsection (a) unless that State agrees that,
10 in developing and carrying out the State plan under
11 subsection (b)(2), the State will provide public notice
12 with respect to the plan (including any revisions
13 thereto) and facilitate comments from interested
14 persons.

15 “(e) NUMBER OF GRANTS.—The Secretary shall
16 award grants under this section to not less than 7 States.

17 “(f) REPORTS.—

18 “(1) REQUIREMENT.—A State that receives a
19 grant under this section shall annually (during each
20 year in which the grant proceeds are used) prepare
21 and submit to the Secretary a report that shall con-
22 tain—

23 “(A) a description of the manner in which
24 the grant proceeds were utilized;

1 “(B) a description of the effectiveness of
2 the air medical transport programs assisted
3 with grant proceeds; and

4 “(C) such other information as the Sec-
5 retary may require.

6 “(2) TERMINATION OF FUNDINGS.—In review-
7 ing reports submitted under paragraph (1), if the
8 Secretary determines that a State is not using
9 amounts provided under a grant awarded under this
10 section in accordance with the State plan submitted
11 by the State under subsection (b), the Secretary may
12 terminate the payment of amounts under such grant
13 to the State until such time as the Secretary deter-
14 mines that the State comes into compliance with
15 such plan.

16 “(g) DEFINITION.—As used in this section, the term
17 ‘rural areas’ means geographic areas that are located out-
18 side of standard metropolitan statistical areas, as identi-
19 fied by the Secretary.

20 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to make grants under
22 this section, \$15,000,000 for fiscal year 1995, and such
23 sums as may be necessary for each for fiscal years 1996
24 and 1997.”.

1 **Subtitle G—Studies and Reports**

2 **SEC. 371. ASSISTANT SECRETARY FOR RURAL HEALTH.**

3 (a) APPOINTMENT OF ASSISTANT SECRETARY.—

4 (1) IN GENERAL.—Section 711(a) of the Social
5 Security Act (42 U.S.C. 912(a)) is amended—

6 (A) by striking “by a Director, who shall
7 advise the Secretary” and inserting “by an As-
8 sistant Secretary for Rural Health (in this sec-
9 tion referred to as the ‘Assistant Secretary’),
10 who shall report directly to the Secretary”; and

11 (B) by adding at the end the following new
12 sentence: “The Office shall not be a component
13 of any other office, service, or component of the
14 Department.”.

15 (2) CONFORMING AMENDMENTS.—(A) Section
16 711(b) of the Social Security Act (42 U.S.C. 912(b))
17 is amended by striking “the Director” and inserting
18 “the Assistant Secretary”.

19 (B) Section 338J(a) of the Public Health Serv-
20 ice Act (42 U.S.C. 254r(a)) is amended by striking
21 “Director of the Office of Rural Health Policy” and
22 inserting “Assistant Secretary for Rural Health”.

23 (C) Section 464T(b) of the Public Health Serv-
24 ice Act (42 U.S.C. 285p–2(b)) is amended in the
25 matter preceding paragraph (1) by striking “Direc-

1 tor of the Office of Rural Health Policy” and insert-
2 ing “Assistant Secretary for Rural Health”.

3 (D) Section 6213 of the Omnibus Budget Rec-
4 onciliation Act of 1989 (42 U.S.C. 1395x note) is
5 amended in subsection (e)(1) by striking “Director
6 of the Office of Rural Health Policy” and inserting
7 “Assistant Secretary for Rural Health”.

8 (E) Section 403 of the Ryan White Comprehen-
9 sive AIDS Resources Emergency Act of 1990 (42
10 U.S.C. 300ff–11 note) is amended in the matter pre-
11 ceding paragraph (1) of subsection (a) by striking
12 “Director of the Office of Rural Health Policy” and
13 inserting “Assistant Secretary for Rural Health”.

14 (3) AMENDMENT TO THE EXECUTIVE SCHED-
15 ULE.—Section 5315 of title 5, United States Code,
16 is amended by striking “Assistant Secretaries of
17 Health and Human Services (5)” and inserting “As-
18 sistant Secretaries of Health and Human Services
19 (6)”.

20 (b) EXPANSION OF DUTIES.—Section 711(a) of the
21 Social Security Act (42 U.S.C. 912(a)) is amended by
22 striking “and access to (and the quality of) health care
23 in rural areas” and inserting “access to, and quality of,
24 health care in rural areas, and reforms to the health care

1 system and the implications of such reforms for rural
2 areas”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall take effect on January 1, 1996.

5 **SEC. 372. STUDY ON TRANSITIONAL MEASURES TO ENSURE**
6 **ACCESS.**

7 (a) IN GENERAL.—The Prospective Payment Assess-
8 ment Commission shall conduct a study concerning the
9 need for legislation or regulations to ensure that vulner-
10 able populations have adequate access to health plans and
11 health care providers and services.

12 (b) REPORT.—Not later than 1 year after the date
13 of enactment of this Act, the Prospective Payment Assess-
14 ment Commission shall prepare and submit to Congress
15 a report concerning the findings and recommendations of
16 the Commission based on the study conducted under sub-
17 section (a).

18 **SEC. 373. STUDY ON EXPANDING BENEFITS UNDER HEALTH**
19 **PLANS FOR INDIVIDUALS RESIDING IN**
20 **RURAL AREAS.**

21 (a) STUDY.—

22 (1) IN GENERAL.—The Secretary shall conduct
23 a study on the possible benefits of a program under
24 which issuers of health plans covering individuals
25 who reside in rural areas may—

1 (A) develop a package of benefits targeted
 2 at improving access to health care services
 3 which would supplement the benefits included
 4 under such plan; and

5 (B) receive premium payments for such
 6 package of benefits from the Secretary under
 7 the Medicare or Medicaid programs.

8 (2) CONSULTATION WITH CERTAIN ENTITIES.—

9 In conducting the study under paragraph (1), the
 10 Secretary shall consult with the Office of Rural
 11 Health Policy and private and public entities with
 12 expertise in rural health issues.

13 (b) REPORT.—Not later than 1 year after the date
 14 of the enactment of this Act the Secretary shall submit
 15 a report to Congress containing the results of the study
 16 conducted under subsection (a) and any legislative rec-
 17 ommendations determined appropriate by the Secretary.

18 **TITLE IV—LONG-TERM CARE** 19 **PROVISIONS**

20 **SEC. 400. AMENDMENT OF INTERNAL REVENUE CODE OF**
 21 **1986.**

22 Except as otherwise expressly provided, whenever in
 23 this title an amendment or repeal is expressed in terms
 24 of an amendment to, or repeal of, a section or other provi-
 25 sion, the reference shall be considered to be made to a

1 section or other provision of the Internal Revenue Code
2 of 1986.

3 **Subtitle A—Long-Term Care** 4 **Services and Contracts**

5 **PART I—GENERAL PROVISIONS**

6 **SEC. 401. QUALIFIED LONG-TERM CARE SERVICES TREAT-** 7 **ED AS MEDICAL CARE.**

8 (a) GENERAL RULE.—Paragraph (1) of section
9 213(d) (defining medical care) is amended by striking
10 “or” at the end of subparagraph (B), by redesignating
11 subparagraph (C) as subparagraph (D), and by inserting
12 after subparagraph (B) the following new subparagraph:

13 “(C) for qualified long-term care services
14 (as defined in subsection (g)), or”.

15 (b) QUALIFIED LONG-TERM CARE SERVICES DE-
16 FINED.—Section 213 (relating to deduction for medical,
17 dental, etc. expenses), as amended by section 101, is
18 amended by adding at the end the following new sub-
19 section:

20 “(g) QUALIFIED LONG-TERM CARE SERVICES.—For
21 purposes of this section—

22 “(1) IN GENERAL.—The term ‘qualified long-
23 term care services’ means necessary diagnostic, pre-
24 ventive, therapeutic, rehabilitative, and maintenance
25 (including personal care) services—

1 “(A) which are required by an individual
2 during any period during which such individual
3 is a functionally impaired individual,

4 “(B) which have as their primary purpose
5 the provision of needed assistance with 1 or
6 more activities of daily living which a function-
7 ally impaired individual is certified as being un-
8 able to perform under paragraph (2)(A), and

9 “(C) which are provided pursuant to a con-
10 tinuing plan of care prescribed by a licensed
11 health care practitioner (other than a relative of
12 such individual).

13 “(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

14 “(A) IN GENERAL.—The term ‘functionally
15 impaired individual’ means any individual who
16 is certified by a licensed health care practitioner
17 (other than a relative of such individual) as
18 being unable to perform, without substantial as-
19 sistance from another individual (including as-
20 sistance involving verbal reminding, physical
21 cueing, or substantial supervision), at least 3
22 activities of daily living described in paragraph
23 (3).

24 “(B) SPECIAL RULE FOR HOME HEALTH
25 CARE SERVICES.—In the case of services which

1 are provided during any period during which an
2 individual is residing within the individual's
3 home (whether or not the services are provided
4 within the home), subparagraph (A) shall be
5 applied by substituting '2' for '3'. For purposes
6 of this subparagraph, a nursing home or similar
7 facility shall not be treated as a home.

8 “(3) ACTIVITIES OF DAILY LIVING.—Each of
9 the following is an activity of daily living:

10 “(A) Eating.

11 “(B) Transferring.

12 “(C) Toileting.

13 “(D) Dressing.

14 “(E) Bathing.

15 “(4) LICENSED HEALTH CARE PRACTI-
16 TIONER.—

17 “(A) IN GENERAL.—The term 'licensed
18 health care practitioner' means—

19 “(i) a physician or registered profes-
20 sional nurse,

21 “(ii) a qualified community care case
22 manager (as defined in subparagraph (B)),
23 or

24 “(iii) any other individual who meets
25 such requirements as may be prescribed by

1 the Secretary after consultation with the
2 Secretary of Health and Human Services.

3 “(B) QUALIFIED COMMUNITY CARE CASE
4 MANAGER.—The term ‘qualified community
5 care case manager’ means an individual or en-
6 tity which—

7 “(i) has experience or has been
8 trained in providing case management
9 services and in preparing individual care
10 plans;

11 “(ii) has experience in assessing indi-
12 viduals to determine their functional and
13 cognitive impairment;

14 “(iii) is not a relative of the individual
15 receiving case management services; and

16 “(iv) meets such requirements as may
17 be prescribed by the Secretary after con-
18 sultation with the Secretary of Health and
19 Human Services.

20 “(5) RELATIVE.—The term ‘relative’ means an
21 individual bearing a relationship to another individ-
22 ual which is described in paragraphs (1) through (8)
23 of section 152(a).”

24 (c) TECHNICAL AMENDMENTS.—

1 (1) Subparagraph (D) of section 213(d)(1) (as
2 redesignated by subsection (a)) is amended to read
3 as follows:

4 “(D) for insurance (including amounts
5 paid as premiums under part B of title XVIII
6 of the Social Security Act, relating to supple-
7 mentary medical insurance for the aged)—

8 “(i) covering medical care referred to
9 in subparagraphs (A) and (B), or

10 “(ii) covering medical care referred to
11 in subparagraph (C), but only if such cov-
12 erage is provided under a qualified long-
13 term care insurance contract (as defined in
14 section 7702B(b)).”

15 (2) Paragraph (6) of section 213(d) is amend-
16 ed—

17 (A) by striking “subparagraphs (A) and
18 (B)” in the matter preceding subparagraph (A)
19 and inserting “subparagraphs (A), (B), and
20 (C)”, and

21 (B) by striking “paragraph (1)(C)” in sub-
22 paragraph (A) and inserting “paragraph
23 (1)(D)”.

1 (3) Paragraph (7) of section 213(d) is amended
2 by striking “subparagraphs (A) and (B)” and insert-
3 ing “subparagraphs (A), (B), and (C)”.

4 **SEC. 402. TREATMENT OF LONG-TERM CARE INSURANCE**
5 **OR PLANS.**

6 (a) GENERAL RULE.—Chapter 79 (relating to defini-
7 tions) is amended by inserting after section 7702A the fol-
8 lowing new section:

9 **“SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE**
10 **OR PLANS.**

11 “(a) GENERAL RULE.—For purposes of this title—

12 “(1) a qualified long-term care insurance con-
13 tract shall be treated as an accident or health insur-
14 ance contract,

15 “(2) any plan of an employer providing cov-
16 erage of qualified long-term care services shall be
17 treated as an accident or health plan with respect to
18 such services,

19 “(3) amounts received under such a contract or
20 plan with respect to qualified long-term care services
21 shall be treated as amounts received for personal in-
22 juries or sickness, and

23 “(4) payments described in subsection (b)(5)
24 shall be treated as payments made with respect to
25 qualified long-term care services.

1 “(b) QUALIFIED LONG-TERM CARE INSURANCE
2 CONTRACT.—

3 “(1) IN GENERAL.—For purposes of this title,
4 the term ‘qualified long-term care insurance con-
5 tract’ means any insurance contract if—

6 “(A) the only insurance protection pro-
7 vided under such contract is coverage of quali-
8 fied long-term care services,

9 “(B) such contract meets the requirements
10 of paragraphs (2), (3), and (4), and

11 “(C) such contract is issued by a qualified
12 issuer.

13 “(2) PREMIUM REQUIREMENTS.—

14 “(A) IN GENERAL.—The requirements of
15 this paragraph are met with respect to a con-
16 tract if such contract provides that—

17 “(i) premium payments may not be
18 made earlier than the date such payments
19 would have been made if the contract pro-
20 vided for level annual payments over the
21 life of the contract (or, if shorter, 20
22 years), and

23 “(ii) all refunds of premiums, and all
24 policyholder dividends or similar amounts,
25 under such contract are to be applied as a

1 reduction in future premiums or to in-
2 crease future benefits.

3 A contract shall not be treated as failing to
4 meet the requirements of clause (i) solely by
5 reason of a provision providing for a waiver of
6 premiums if the policyholder becomes a func-
7 tionally impaired individual.

8 “(B) REFUNDS UPON DEATH OR COM-
9 PLETE SURRENDER OR CANCELLATION.—Sub-
10 paragraph (A)(ii) shall not apply to any refund
11 on the death of the policyholder, or on any com-
12 plete surrender or cancellation of the contract,
13 if, under the contract, the amount refunded
14 may not exceed the amount of the premiums
15 paid under the contract. For purposes of this
16 title, any refund described in the preceding sen-
17 tence shall be includible in gross income to the
18 extent that any deduction or exclusion was al-
19 lowed with respect to the refund.

20 “(3) BORROWING, PLEDGING, OR ASSIGNING
21 PROHIBITED.—The requirements of this paragraph
22 are met with respect to a contract if such contract
23 provides that no money may be borrowed under such
24 contract and that such contract (or any portion

1 thereof) may not be assigned or pledged as collateral
2 for a loan.

3 “(4) PROHIBITION OF DUPLICATE PAYMENT.—
4 The requirements of this paragraph are met with re-
5 spect to a contract if such contract does not cover
6 expenses incurred to the extent that such expenses
7 are reimbursable under title XVIII of the Social Se-
8 curity Act.

9 “(5) PER DIEM AND OTHER PERIODIC PAY-
10 MENTS PERMITTED.—

11 “(A) IN GENERAL.—For purposes of sub-
12 section (a)(4), and except as provided in sub-
13 paragraph (B), payments are described in this
14 paragraph for any calendar year if, under the
15 contract, such payments are made to (or on be-
16 half of) a functionally impaired individual on a
17 per diem or other periodic basis without regard
18 to the expenses incurred or services rendered
19 during the period to which the payments relate.

20 “(B) EXCEPTION WHERE AGGREGATE PAY-
21 MENTS EXCEED LIMIT.—If the aggregate pay-
22 ments under the contract for any period
23 (whether on a periodic basis or otherwise) ex-
24 ceed the dollar amount in effect for such pe-
25 riod—

1 “(i) subparagraph (A) shall not apply
2 for such period, and

3 “(ii) the requirements of paragraph
4 (1)(A) shall be met only if such payments
5 are made with respect to qualified long-
6 term care services provided during such
7 period.

8 “(C) DOLLAR AMOUNT.—The dollar
9 amount in effect under this paragraph shall be
10 \$150 per day (or the equivalent amount in the
11 case of payments on another periodic basis).

12 “(D) ADJUSTMENTS FOR INCREASED
13 COSTS.—

14 “(i) IN GENERAL.—In the case of any
15 calendar year after 1995, the dollar
16 amount in effect under subparagraph (C)
17 for any period occurring during such cal-
18 endar year shall be equal to the sum of—

19 “(I) the amount in effect under
20 subparagraph (C) for the preceding
21 calendar year (after application of this
22 subparagraph), plus

23 “(II) the applicable percentage of
24 the amount under subclause (I).

1 “(ii) APPLICABLE PERCENTAGE.—For
2 purposes of clause (i), the term ‘applicable
3 percentage’ means, with respect to any cal-
4 endar year, the greater of—

5 “(I) 5 percent, or

6 “(II) the cost-of-living adjust-
7 ment for such calendar year.

8 “(iii) COST-OF-LIVING ADJUST-
9 MENT.—For purposes of clause (ii), the
10 cost-of-living adjustment for any calendar
11 year is the percentage (if any) by which
12 the cost index under clause (iv) for the
13 preceding calendar year exceeds such index
14 for the second preceding calendar year. In
15 the case of any calendar year beginning be-
16 fore 1997, this clause shall be applied by
17 substituting the Consumer Price Index (as
18 defined in section 1(f)(5)) for the cost
19 index under clause (iv).

20 “(iv) COST INDEX.—The Secretary, in
21 consultation with the Secretary of Health
22 and Human Services, shall before January
23 1, 1997, establish a cost index to measure
24 increases in costs of nursing home and
25 similar facilities. The Secretary may from

1 time to time revise such index to the extent
2 necessary to accurately measure increases
3 or decreases in such costs.

4 “(E) AGGREGATION RULE.—For purposes
5 of this paragraph, all contracts issued with re-
6 spect to the same policyholder by the same
7 company shall be treated as 1 contract.

8 “(c) QUALIFIED ISSUER.—For purposes of this sec-
9 tion, the term ‘qualified issuer’ means any person which
10 at the time of the issuance of a long-term care insurance
11 contract—

12 “(1) uses a one year preliminary term method
13 for setting up reserves, and

14 “(2) maintains a capital ratio equal to not less
15 than 25 percent of long-term care insurance pre-
16 mium receivables.

17 “(d) SPECIAL RULES FOR TAX TREATMENT OF POL-
18 ICYHOLDERS.—For purposes of this title, solely with re-
19 spect to the policyholder under any qualified long-term
20 care insurance contract—

21 “(1) AGGREGATE PAYMENTS IN EXCESS OF
22 LIMITS.—If the aggregate payments under all quali-
23 fied long-term care insurance contracts with respect
24 to an policyholder for any period (whether on a peri-

1 odic basis or otherwise) exceed the dollar amount in
2 effect for such period under subsection (b)(5)—

3 “(A) subsection (b)(5) shall not apply for
4 such period, and

5 “(B) such payments shall be treated as
6 made for qualified long-term care services only
7 if made with respect to such services provided
8 during such period.

9 “(2) ASSIGNMENT OR PLEDGE.—Such contract
10 shall not be treated as a qualified long-term care in-
11 surance contract during any period on or after the
12 date on which the contract (or any portion thereof)
13 is assigned or pledged as collateral for a loan.

14 “(e) TREATMENT OF COVERAGE AS PART OF A LIFE
15 INSURANCE CONTRACT.—Except as provided in regula-
16 tions, in the case of coverage of qualified long-term care
17 services provided as part of a life insurance contract, the
18 requirements of this section shall apply as if the portion
19 of the contract providing such coverage was a separate
20 contract.

21 “(f) QUALIFIED LONG-TERM CARE SERVICES.—For
22 purposes of this section—

23 “(1) IN GENERAL.—The term ‘qualified long-
24 term care services’ has the meaning given such term
25 by section 213(g).

1 “(2) RECERTIFICATION.—If an individual has
2 been certified as a functionally impaired individual
3 under section 213(g)(2)(A), services shall not be
4 treated as qualified long-term care services with re-
5 spect to the individual unless such individual is
6 recertified no less frequently than annually as a
7 functionally impaired individual in the same manner
8 as under such section, except that such
9 recertification may be made by any licensed health
10 care practitioner (as defined in section 213(g)(4)),
11 other than a relative (as defined by section
12 213(g)(5)) of such individual.

13 “(g) CONTINUATION COVERAGE EXCISE TAX NOT
14 TO APPLY.—Section 4980B shall not apply to—

15 “(1) qualified long-term care insurance con-
16 tracts, or

17 “(2) plans described in subsection (a)(2).

18 “(h) REGULATIONS.—The Secretary shall prescribe
19 such regulations as may be necessary to carry out the re-
20 quirements of this section, including regulations to prevent
21 the avoidance of this section by providing qualified long-
22 term care services under a life insurance contract.”

23 “(b) CAFETERIA PLANS.—Section 125(f) is amended
24 by adding at the end the following new sentence: “Such
25 term does not include any coverage or benefits under a

1 qualified long-term care insurance contract (as defined in
2 section 7702B).”

3 (c) RESERVES.—Clause (iii) of section 807(d)(3)(A)
4 is amended by inserting “(other than a qualified long-term
5 care insurance contract within the meaning of section
6 7702B)” after “contract”.

7 (d) CLERICAL AMENDMENT.—The table of sections
8 for chapter 79 is amended by inserting after the item re-
9 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance or plans.”

10 **SEC. 403. EFFECTIVE DATES.**

11 (a) SECTION 401.—The amendments made by section
12 401 shall apply to taxable years beginning after December
13 31, 1994.

14 (b) SECTION 402.—The amendments made by sec-
15 tion 402 shall apply to contracts issued after December
16 31, 1994.

17 (c) TRANSITION RULE.—If, after the date of the en-
18 actment of this Act and before January 1, 1995, a con-
19 tract providing coverage for services which are similar to
20 qualified long-term care services (as defined in section
21 213(g) of the Internal Revenue Code of 1986) and issued
22 on or before January 1, 1994, is exchanged for a qualified
23 long-term care insurance contract (as defined in section
24 7702B(b) of such Code), such exchange shall be treated

1 as an exchange to which section 1035 of such Code ap-
 2 plies.

3 **PART II—CONSUMER PROTECTION PROVISIONS**

4 **SEC. 406. POLICY REQUIREMENTS.**

5 (a) IN GENERAL.—Section 7702B (as added by sec-
 6 tion 402) is amended by redesignating subsection (h) as
 7 subsection (i) and by inserting after subsection (g) the fol-
 8 lowing new subsection:

9 “(h) CONSUMER PROTECTION PROVISIONS.—

10 “(1) IN GENERAL.—The requirements of this
 11 subsection are met with respect to any contract if
 12 any long-term care insurance policy issued under the
 13 contract meets—

14 “(A) the requirements of the model regula-
 15 tion and model Act described in paragraph (2),

16 “(B) the disclosure requirement of para-
 17 graph (3),

18 “(C) the requirements relating to
 19 nonforfeitability under paragraph (4), and

20 “(D) the requirements relating to rate sta-
 21 bilization under paragraph (5).

22 “(2) REQUIREMENTS OF MODEL REGULATION
 23 AND ACT.—

1 “(A) IN GENERAL.—The requirements of
2 this paragraph are met with respect to any pol-
3 icy if such policy meets—

4 “(i) MODEL REGULATION.—The fol-
5 lowing requirements of the model regula-
6 tion:

7 “(I) Section 7A (relating to guar-
8 anteed renewal or noncancellability),
9 and the requirements of section 6B of
10 the model Act relating to such section
11 7A.

12 “(II) Section 7B (relating to pro-
13 hibitions on limitations and exclu-
14 sions).

15 “(III) Section 7C (relating to ex-
16 tension of benefits).

17 “(IV) Section 7D (relating to
18 continuation or conversion of cov-
19 erage).

20 “(V) Section 7E (relating to dis-
21 continuance and replacement of poli-
22 cies).

23 “(VI) Section 8 (relating to unin-
24 tentional lapse).

1 “(VII) Section 9 (relating to dis-
2 closure), other than section 9F there-
3 of.

4 “(VIII) Section 10 (relating to
5 prohibitions against post-claims un-
6 derwriting).

7 “(IX) Section 11 (relating to
8 minimum standards).

9 “(X) Section 12 (relating to re-
10 quirement to offer inflation protec-
11 tion), except that any requirement for
12 a signature on a rejection of inflation
13 protection shall permit the signature
14 to be on an application or on a sepa-
15 rate form.

16 “(XI) Section 23 (relating to pro-
17 hibition against preexisting conditions
18 and probationary periods in replace-
19 ment policies or certificates).

20 “(ii) MODEL ACT.—The following re-
21 quirements of the model Act:

22 “(I) Section 6C (relating to pre-
23 existing conditions).

24 “(II) Section 6D (relating to
25 prior hospitalization).

1 “(B) DEFINITIONS.—For purposes of this
2 paragraph—

3 “(i) MODEL PROVISIONS.—The terms
4 ‘model regulation’ and ‘model Act’ mean
5 the long-term care insurance model regula-
6 tion, and the long-term care insurance
7 model Act, respectively, promulgated by
8 the National Association of Insurance
9 Commissioners (as adopted in January of
10 1993).

11 “(ii) COORDINATION.—Any provision
12 of the model regulation or model Act listed
13 under clause (i) or (ii) of subparagraph
14 (A) shall be treated as including any other
15 provision of such regulation or Act nec-
16 essary to implement the provision.

17 “(3) TAX DISCLOSURE REQUIREMENT.—The re-
18 quirement of this paragraph is met with respect to
19 any policy if such policy meets the requirements of
20 section 4980C(d)(1).

21 “(4) NONFORFEITURE REQUIREMENTS.—

22 “(A) IN GENERAL.—The requirements of
23 this paragraph are met with respect to any level
24 premium long-term care insurance policy, if the
25 issuer of such policy offers to the policyholder,

1 including any group policyholder, a
2 nonforfeiture provision meeting the require-
3 ments of subparagraph (B).

4 “(B) REQUIREMENTS OF PROVISION.—The
5 nonforfeiture provision required under subpara-
6 graph (A) shall meet the following require-
7 ments:

8 “(i) The nonforfeiture provision shall
9 be appropriately captioned.

10 “(ii) The nonforfeiture provision shall
11 provide for a benefit available in the event
12 of a default in the payment of any pre-
13 miums and the amount of the benefit may
14 be adjusted subsequent to being initially
15 granted only as necessary to reflect
16 changes in claims, persistency, and interest
17 as reflected in changes in rates for pre-
18 mium paying policies approved by the Sec-
19 retary for the same policy form.

20 “(iii) The nonforfeiture provision shall
21 provide at least one of the following:

22 “(I) Reduced paid-up insurance.

23 “(II) Extended term insurance.

24 “(III) Shortened benefit period.

1 “(IV) Other similar offerings ap-
2 proved by the Secretary.

3 “(5) RATE STABILIZATION.—

4 “(A) IN GENERAL.—The requirements of
5 this paragraph are met with respect to any
6 long-term care insurance policy, including any
7 group master policy, if—

8 “(i) such policy contains the minimum
9 rate guarantees specified in subparagraph
10 (B), and

11 “(ii) the issuer of such policy meets
12 the requirements specified in subparagraph
13 (C).

14 “(B) MINIMUM RATE GUARANTEES.—The
15 minimum rate guarantees specified in this sub-
16 paragraph are as follows:

17 “(i) Rates under the policy shall be
18 guaranteed for a period of at least 3 years
19 from the date of issue of the policy.

20 “(ii) After the expiration of the 3-year
21 period required under clause (i), any rate
22 increase shall be guaranteed for a period of
23 at least 2 years from the effective date of
24 such rate increase.

1 “(iii) In the case of any individual age
2 75 or older who has maintained coverage
3 under a long-term care insurance policy for
4 10 years, rate increases under such policy
5 shall not exceed 10 percent in any 12-
6 month period.

7 “(C) INCREASES IN PREMIUMS.—The re-
8 quirements specified in this subparagraph are
9 as follows:

10 “(i) IN GENERAL.—If an issuer of any
11 long-term care insurance policy, including
12 any group master policy, plans to increase
13 the premium rates for a policy, such issuer
14 shall, at least 90 days before the effective
15 date of the rate increase, offer to each in-
16 dividual policyholder under such policy the
17 option to remain insured under the policy
18 at a reduced level of benefits which main-
19 tains the premium rate at the rate in effect
20 on the day before the effective date of the
21 rate increase.

22 “(ii) INCREASES OF MORE THAN 50
23 PERCENT.—

24 “(I) IN GENERAL.—If an issuer
25 of any long-term care insurance pol-

1 icy, including any group master pol-
2 icy, increases premium rates for a pol-
3 icy by more than 50 percent in any 3-
4 year period—

5 “(aa) in the case of a group
6 master long-term care insurance
7 policy, the issuer shall dis-
8 continue issuing all group master
9 long-term care insurance policies
10 in any State in which the issuer
11 issues such policy for a period of
12 2 years from the effective date of
13 such premium increase; and

14 “(bb) in the case of an indi-
15 vidual long-term care insurance
16 policy, the issuer shall dis-
17 continue issuing all individual
18 long-term care policies in any
19 State in which the issuer issues
20 such policy for a period of 2
21 years from the effective date of
22 such premium increase.

23 “(II) APPLICABILITY.—Subclause
24 (I) shall apply to any issuer of long-
25 term care insurance policies or any

1 other person that purchases or other-
2 wise acquires any long-term care in-
3 surance policies from another issuer
4 or person.

5 “(D) MODIFICATIONS OR WAIVERS OF RE-
6 QUIREMENTS.—The Secretary may modify or
7 waive any of the requirements under this para-
8 graph if—

9 “(i) such requirements will adversely
10 affect an issuer’s solvency;

11 “(ii) such modification or waiver is re-
12 quired for the issuer to meet other State or
13 Federal requirements;

14 “(iii) medical developments, new dis-
15 abling diseases, changes in long-term care
16 delivery, or a new method of financing
17 long-term care will result in changes to
18 mortality and morbidity patterns or as-
19 sumptions;

20 “(iv) judicial interpretation of a pol-
21 icy’s benefit features results in unintended
22 claim liabilities; or

23 “(v) in the case of a purchase or other
24 acquisition of long-term care insurance
25 policies of an issuer or other person, the

1 continued sale of other long-term care in-
 2 surance policies by the purchasing issuer
 3 or person is in the best interests of individ-
 4 ual consumers.

5 “(6) LONG-TERM CARE INSURANCE POLICY DE-
 6 FINED.—For purposes of this subsection, the term
 7 ‘long-term care insurance policy’ has the meaning
 8 given such term by section 4980C(e).”

9 (b) CONFORMING AMENDMENT.—Section
 10 7702B(b)(1)(B) (as added by section 402) is amended by
 11 inserting “and of subsection (h)” after “and (4)”.

12 **SEC. 407. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**
 13 **LONG-TERM CARE INSURANCE POLICIES.**

14 (a) IN GENERAL.—Chapter 43 is amended by adding
 15 at the end the following new section:

16 **“SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-**
 17 **TERM CARE INSURANCE POLICIES.**

18 “(a) GENERAL RULE.—There is hereby imposed on
 19 any person failing to meet the requirements of subsection
 20 (c) or (d) a tax in the amount determined under sub-
 21 section (b).

22 “(b) AMOUNT OF TAX.—

23 “(1) IN GENERAL.—The amount of the tax im-
 24 posed by subsection (a) shall be \$100 per policy for
 25 each day any requirements of subsection (c), (d), or

1 (e) are not met with respect to each long-term care
2 insurance policy.

3 “(2) WAIVER.—In the case of a failure which is
4 due to reasonable cause and not to willful neglect,
5 the Secretary may waive part or all of the tax im-
6 posed by subsection (a) to the extent that payment
7 of the tax would be excessive relative to the failure
8 involved.

9 “(c) ADDITIONAL RESPONSIBILITIES.—The require-
10 ments of this subsection are as follows:

11 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

12 “(A) MODEL REGULATION.—The following
13 requirements of the model regulation must be
14 met:

15 “(i) Section 13 (relating to application
16 forms and replacement coverage).

17 “(ii) Section 14 (relating to reporting
18 requirements), except that the issuer shall
19 also report at least annually the number of
20 claims denied during the reporting period
21 for each class of business (expressed as a
22 percentage of claims denied), other than
23 claims denied for failure to meet the wait-
24 ing period or because of any applicable
25 pre-existing condition.

1 “(iii) Section 20 (relating to filing re-
2 requirements for marketing).

3 “(iv) Section 21 (relating to standards
4 for marketing), including inaccurate com-
5 pletion of medical histories, other than sec-
6 tions 21C(1) and 21C(6) thereof, except
7 that—

8 “(I) in addition to such require-
9 ments, no person shall, in selling or
10 offering to sell a long-term care insur-
11 ance policy, misrepresent a material
12 fact; and

13 “(II) no such requirements shall
14 include a requirement to inquire or
15 identify whether a prospective appli-
16 cant or enrollee for long-term care in-
17 surance has accident and sickness in-
18 surance.

19 “(v) Section 22 (relating to appro-
20 priateness of recommended purchase).

21 “(vi) Section 24 (relating to standard
22 format outline of coverage).

23 “(vii) Section 25 (relating to require-
24 ment to deliver shopper’s guide).

1 “(B) MODEL ACT.—The following require-
2 ments of the model Act must be met:

3 “(i) Section 6F (relating to right to
4 return), except that such section shall also
5 apply to denials of applications and any re-
6 fund shall be made within 30 days of the
7 return or denial.

8 “(ii) Section 6G (relating to outline of
9 coverage).

10 “(iii) Section 6H (relating to require-
11 ments for certificates under group plans).

12 “(iv) Section 6I (relating to policy
13 summary).

14 “(v) Section 6J (relating to monthly
15 reports on accelerated death benefits).

16 “(vi) Section 7 (relating to incontest-
17 ability period).

18 “(C) DEFINITIONS.—For purposes of this
19 paragraph, the terms ‘model regulation’ and
20 ‘model Act’ have the meanings given such terms
21 by section 7702B(h)(2)(B).

22 “(2) DELIVERY OF POLICY.—If an application
23 for a long-term care insurance policy (or for a cer-
24 tificate under a group long-term care insurance pol-
25 icy) is approved, the issuer shall deliver to the appli-

1 cant (or policyholder or certificate-holder) the policy
2 (or certificate) of insurance not later than 30 days
3 after the date of the approval.

4 “(3) INFORMATION ON DENIALS OF CLAIMS.—
5 If a claim under a long-term care insurance policy
6 is denied, the issuer shall, within 60 days of the date
7 of a written request by the policyholder or certifi-
8 cate-holder (or representative)—

9 “(A) provide a written explanation of the
10 reasons for the denial, and

11 “(B) make available all information di-
12 rectly relating to such denial.

13 “(d) DISCLOSURE.—The requirements of this sub-
14 section are met if either of the following statements,
15 whichever is applicable, is prominently displayed on the
16 front page of any long-term care insurance policy and in
17 the outline of coverage required under subsection
18 (c)(1)(B)(ii):

19 “(1) A statement that: ‘This policy is intended
20 to be a qualified long-term care insurance contract
21 under section 7702B(b) of the Internal Revenue
22 Code of 1986.’.

23 “(2) A statement that: ‘This policy is not in-
24 tended to be a qualified long-term care insurance

1 contract under section 7702B(b) of the Internal
2 Revenue Code of 1986.’.

3 “(e) LONG-TERM CARE INSURANCE POLICY DE-
4 FINED.—For purposes of this section, the term ‘long-term
5 care insurance policy’ means any product which is adver-
6 tised, marketed, or offered as long-term care insurance.”

7 (b) CONFORMING AMENDMENT.—The table of sec-
8 tions for chapter 43 is amended by adding at the end the
9 following new item:

“Sec. 4980C. Failure to meet requirements for long-term care in-
surance policies.”

10 **SEC. 408. COORDINATION WITH STATE REQUIREMENTS.**

11 Nothing in this part shall be construed as preventing
12 a State from applying standards that provide greater pro-
13 tection of policyholders of long-term care insurance poli-
14 cies (as defined in section 4980C(e) of the Internal Reve-
15 nue Code of 1986).

16 **SEC. 409. UNIFORM LANGUAGE AND DEFINITIONS.**

17 (a) IN GENERAL.—The National Association of In-
18 surance Commissioners shall not later than January 1,
19 1996, promulgate standards for the use of uniform lan-
20 guage and definitions in long-term care insurance policies
21 (as defined in section 4980C(e) of the Internal Revenue
22 Code 1986).

23 (b) VARIATIONS.—Standards under subsection (a)
24 may permit the use of nonuniform language to the extent

1 required to take into account differences among States in
2 the licensing of nursing facilities and other providers of
3 long-term care.

4 **SEC. 410. EFFECTIVE DATES.**

5 (a) IN GENERAL.—The provisions of, and amend-
6 ments made by, this part shall apply to contracts issued
7 after December 31, 1994. The provisions of section 403(c)
8 of this Act shall apply to such contracts.

9 (b) ISSUERS.—The amendments made by section 407
10 shall apply to actions taken after December 31, 1994.

11 **Subtitle B—Tax Treatment of**
12 **Accelerated Death Benefits**

13 **SEC. 411. TAX TREATMENT OF ACCELERATED DEATH BENE-**
14 **FITS UNDER LIFE INSURANCE CONTRACTS.**

15 (a) GENERAL RULE.—Section 101 (relating to cer-
16 tain death benefits) is amended by adding at the end the
17 following new subsection:

18 “(g) TREATMENT OF CERTAIN ACCELERATED
19 DEATH BENEFITS.—

20 “(1) IN GENERAL.—For purposes of this sec-
21 tion, any amount received under a life insurance
22 contract on the life of an insured who is a terminally
23 ill individual shall be treated as an amount paid by
24 reason of the death of such insured.

25 “(2) NECESSARY CONDITIONS.—

1 “(A) IN GENERAL.—Paragraph (1) shall
2 not apply to any amount received unless—

3 “(i) the total amount received is not
4 less than the present value (determined
5 under subparagraph (B)) of the reduction
6 in the death benefit otherwise payable in
7 the event of the death of the insured, and

8 “(ii) the percentage reduction in the
9 cash surrender value of the contract by
10 reason of the distribution does not exceed
11 the percentage reduction in the death ben-
12 efit payable under the contract by reason
13 of such distribution.

14 “(B) PRESENT VALUE.—The present value
15 of the reduction in the death benefit shall be
16 determined by—

17 “(i) using a discount rate which is
18 based on an interest rate which does not
19 exceed the highest interest rate set forth in
20 subparagraph (C), and

21 “(ii) assuming that the death benefit
22 (or the portion thereof) would have been
23 paid on the date which is 12 months after
24 the date of the certification referred to in
25 paragraph (3).

1 “(C) RATES.—The interest rates set forth
2 in this subparagraph are the following:

3 “(i) the 90-day Treasury bill yield,

4 “(ii) the rate described as Moody’s
5 Corporate Bond Yield Average-Monthly
6 Average Corporates as published by
7 Moody’s Investors Service, Inc., or any
8 successor thereto, for the calendar month
9 ending 2 months before the date on which
10 the rate is determined, and

11 “(iii) the rate used to compute the
12 cash surrender values under the contract
13 during the applicable period plus 1 percent
14 per annum.

15 “(D) SPECIAL RULES RELATING TO
16 LIENS.—If a lien is imposed against a life in-
17 surance contract with respect to any amount re-
18 ferred to in paragraph (1)—

19 “(i) for purposes of subparagraph (A),
20 the amount of such lien shall be treated as
21 a reduction (at the time of receipt) in the
22 death benefit or cash surrender value to
23 the extent that such benefit or value, as
24 the case may be, is (or may become) sub-
25 ject to the lien, and

1 “(ii) paragraph (1) shall not apply to
2 the amount received unless any rate of in-
3 terest with respect to any amount in con-
4 nection with which such lien is imposed
5 does not exceed the highest rate set forth
6 in subparagraph (C).

7 “(3) TERMINALLY ILL INDIVIDUAL.—For pur-
8 poses of this subsection, the term ‘terminally ill indi-
9 vidual’ means an individual who the insurer has de-
10 termined, after receipt of an acceptable certification
11 by a licensed physician, has an illness or physical
12 condition which can reasonably be expected to result
13 in death within 12 months after the date of certifi-
14 cation.

15 “(4) EXCEPTION FOR BUSINESS-RELATED POLI-
16 CIES.—This subsection shall not apply in the case of
17 any amount paid to any taxpayer other than the in-
18 sured if such taxpayer has an insurable interest with
19 respect to the life of the insured by reason of the in-
20 sured being a director, officer, or employee of the
21 taxpayer or by reason of the insured having a finan-
22 cial interest in any trade or business carried on by
23 the taxpayer.”

24 (b) EFFECTIVE DATES.—

1 (1) IN GENERAL.—Except as provided in para-
 2 graph (2), the amendment made by this section shall
 3 apply to amounts received after the date of the en-
 4 actment of this Act.

5 (2) DELAY IN APPLICATION OF DISCOUNT
 6 RULES.—Clause (i) of section 101(g)(2)(A) of the
 7 Internal Revenue Code of 1986 shall not apply to
 8 any amount received before January 1, 1995.

9 (3) ISSUANCE OF RIDER NOT TREATED AS MA-
 10 TERIAL CHANGE.—For purposes of applying section
 11 101(f), 7702, or 7702A of the Internal Revenue
 12 Code of 1986 to any contract, the issuance of a
 13 qualified accelerated death benefit rider (as defined
 14 in section 818(g) of such Code (as added by this
 15 Act)) shall not be treated as a modification or mate-
 16 rial change of such contract.

17 **SEC. 412. TAX TREATMENT OF COMPANIES ISSUING QUALI-**
 18 **FIED ACCELERATED DEATH BENEFIT RID-**
 19 **ERS.**

20 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
 21 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-
 22 ing to other definitions and special rules) is amended by
 23 adding at the end the following new subsection:

“(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

8 “(2) QUALIFIED ACCELERATED DEATH BENE-
9 FIT RIDERS.—For purposes of this subsection, the
10 term ‘qualified accelerated death benefit rider’
11 means any rider on a life insurance contract which
12 provides for a distribution to an individual upon the
13 insured becoming a terminally ill individual (as de-
14 fined in section 101(g)(3)).”

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle C—Credit for Personal Assistance

19 **SEC. 421. CREDIT FOR COST OF PERSONAL ASSISTANCE**
20 **SERVICES REQUIRED BY EMPLOYED INDIVID-**
21 **UALS.**

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 23 the following new section:

1 **“SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES RE-**
2 **QUIRED BY EMPLOYED INDIVIDUALS.**

3 “(a) ALLOWANCE OF CREDIT.—

4 “(1) IN GENERAL.—In the case of an eligible
5 individual, there shall be allowed as a credit against
6 the tax imposed by this chapter for the taxable year
7 an amount equal to the applicable percentage of the
8 personal assistance expenses paid or incurred by the
9 taxpayer during such taxable year.

10 “(2) APPLICABLE PERCENTAGE.—For purposes
11 of paragraph (1), the term ‘applicable percentage’
12 means 50 percent reduced (but not below zero) by
13 10 percentage points for each \$5,000 by which the
14 modified adjusted gross income (as defined in sec-
15 tion 59B(d)(2)) of the taxpayer for the taxable year
16 exceeds \$45,000. In the case of a married individual
17 filing a separate return, the preceding sentence shall
18 be applied by substituting ‘\$2,500’ for ‘\$5,000’ and
19 ‘\$22,500’ for ‘\$45,000’.

20 “(b) LIMITATION.—The amount of personal assist-
21 ance expenses for the benefit of an individual which may
22 be taken into account under subsection (a) for the taxable
23 year shall not exceed the lesser of—

24 “(1) \$15,000, or

25 “(2) such individual’s earned income (as de-
26 fined in section 32(c)(2)) for the taxable year.

1 In the case of a joint return, the amount under the preced-
2 ing sentence shall be determined separately for each
3 spouse.

4 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this
5 section, the term ‘eligible individual’ means any individual
6 (other than a nonresident alien) who, by reason of any
7 medically determinable physical impairment which can be
8 expected to result in death or which has lasted or can be
9 expected to last for a continuous period of not less than
10 12 months, is unable to engage in any substantial gainful
11 employment activity without personal assistance services
12 appropriate to carry out activities of daily living. An indi-
13 vidual shall not be treated as an eligible individual unless
14 such individual furnishes such proof thereof (in such form
15 and manner, and at such times) as the Secretary may re-
16 quire.

17 “(d) OTHER DEFINITIONS.—For purposes of this
18 section—

19 “(1) PERSONAL ASSISTANCE EXPENSES.—The
20 term ‘personal assistance expenses’ means expenses
21 for—

22 “(A) personal assistance services appro-
23 priate to carry out activities of daily living in or
24 outside the home,

1 “(B) homemaker/chore services incidental
2 to the provision of such personal assistance
3 services,

4 “(C) communication services,

5 “(D) work-related support services,

6 “(E) coordination of services described in
7 this paragraph,

8 “(F) technology and devices necessary to
9 assist an individual in carrying out the activi-
10 ties of daily living or gainful employment activi-
11 ties, including assessment of the need for par-
12 ticular technology and devices and training of
13 family members, and

14 “(G) modifications to the principal place of
15 abode of the individual to the extent the ex-
16 penses for such modifications would (but for
17 subsection (e)(2)) be expenses for medical care
18 (as defined by section 213) of such individual.

19 “(2) ACTIVITIES OF DAILY LIVING.—The term
20 ‘activities of daily living’ means eating, toileting,
21 transferring, bathing, and dressing.

22 “(e) SPECIAL RULES.—

23 “(1) PAYMENTS TO RELATED PERSONS.—No
24 credit shall be allowed under this section for any
25 amount paid by the taxpayer to any person who is

1 related (within the meaning of section 267 or
2 707(b)) to the taxpayer.

3 “(2) COORDINATION WITH MEDICAL EXPENSE
4 DEDUCTION.—Any amount taken into account in de-
5 termining the credit under this section shall not be
6 taken into account in determining the amount of the
7 deduction under section 213.

8 “(3) BASIS REDUCTION.—For purposes of this
9 subtitle, if a credit is allowed under this section for
10 any expense with respect to any property, the in-
11 crease in the basis of such property which would
12 (but for this paragraph) result from such expense
13 shall be reduced by the amount of the credit so al-
14 lowed.

15 “(f) COST-OF-LIVING ADJUSTMENT.—In the case of
16 any taxable year beginning after 1996, the \$45,000 and
17 \$22,500 amounts in subsection (a)(2) and the \$15,000
18 amount in subsection (b) shall be increased by an amount
19 equal to—

20 “(1) such dollar amount, multiplied by

21 “(2) the cost-of-living adjustment determined
22 under section 1(f)(3) for the calendar year in which
23 the taxable year begins by substituting ‘calendar
24 year 1995’ for ‘calendar year 1992’ in subparagraph
25 (B) thereof.

1 If any increase determined under the preceding sentence
2 is not a multiple of \$1,000, such increase shall be rounded
3 to the nearest multiple of \$1,000.”

4 (b) TECHNICAL AMENDMENT.—Subsection (a) of
5 section 1016 is amended by striking “and” at the end of
6 paragraph (24), by striking the period at the end of para-
7 graph (25) and inserting “, and”, and by adding at the
8 end thereof the following new paragraph:

9 “(26) in the case of any property with respect
10 to which a credit has been allowed under section 24,
11 to the extent provided in section 24(e)(3).”

12 (c) CLERICAL AMENDMENT.—The table of sections
13 for subpart A of part IV of subchapter A of chapter 1
14 is amended by inserting after the item relating to section
15 23 the following new item:

“Sec. 24. Cost of personal assistance services required by em-
ployed individuals.”

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 1995.

**TITLE V—HEALTH CARE
PROVIDERS
Subtitle A—Education and
Research**

SEC. 501. ADVISORY COMMISSION ON WORKFORCE.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(j) ADVISORY COMMISSION ON WORK FORCE.—

“(1) ESTABLISHMENT.—The Director of the Congressional Office of Technology Assessment (in this subsection referred to as the ‘Director’ and the ‘Office’, respectively) shall provide for the appointment of an Advisory Commission on Workforce (in this subsection referred to as the ‘Advisory Commission’) without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

“(2) MEMBERSHIP.—

“(A) COMPOSITION.—The Commission shall consist of 17 individuals with expertise in medical education, the operation of teaching hospitals, the operation of health plans, and other interested individuals.

1 “(B) TERMS.—Members of the Commis-
2 sion shall first be appointed by no later than
3 October 1, 1995, for a term of 3 years, except
4 that the Director may provide initially for such
5 shorter terms as will ensure that (on a continu-
6 ing basis) the terms of no more than 4 mem-
7 bers expire in any 1 year.

8 “(C) CHAIR AND VICE CHAIR.—The Com-
9 mission shall select a Chair and Vice Chair
10 from among its members.

11 “(3) MEETINGS.—

12 “(A) IN GENERAL.—The Commission shall
13 meet at the call of the Chair.

14 “(B) INITIAL MEETING.—No later than 30
15 days after the date on which all members of the
16 Commission have been appointed, the Commis-
17 sion shall hold its first meeting.

18 “(C) QUORUM.—A majority of the mem-
19 bers of the Commission shall constitute a
20 quorum, but a lesser number of members may
21 hold hearings.

22 “(4) DUTIES OF THE COMMISSION.—

23 “(A) IN GENERAL.—The Commission shall
24 not later than October 1, 1996, submit to the
25 Committee on Finance and the Committee on

1 Labor and Human Resources of the Senate and
2 the Committee on Ways and Means, the Com-
3 mittee on Education and Labor, and the Com-
4 mittee on Energy and Commerce of the House
5 of Representatives a report on national health
6 care workforce policy and payment that in-
7 cludes—

8 “(i) assessments and recommenda-
9 tions, as appropriate, in the following
10 areas:

11 “(I) The composition of the phy-
12 sician and non-physician national
13 health care workforce and how such
14 composition addresses the needs of
15 the health care market.

16 “(II) Sources and uses of funds
17 related to graduate medical education
18 and options for future payment policy.

19 (III) Current payment distribu-
20 tion methods related to graduate med-
21 ical education and options for future
22 distribution policy.

23 “(IV) Current incentives to en-
24 courage health care practitioners to
25 enter primary health care specialty

1 areas and to provide services in un-
2 derserved areas and options for future
3 policies.

4 “(V) Current role, composition,
5 distribution, and costs related to for-
6 eign medical graduates in the national
7 health care workforce and options for
8 future policies;

9 “(ii) recommendations for a coordi-
10 nated policy for the future direction and
11 distribution of grants, demonstration
12 projects, and other funding affecting the
13 health care workforce; and

14 (iii) recommendations and a schedule
15 for topics to be addressed in subsequent
16 quarterly reports, based on the findings
17 and recommendations of the Commission
18 described in the previous clauses.

19 “(5) CONSULTATION.—The Commission shall
20 develop its recommendations and assessments under
21 this subsection in consultation with the Physician
22 Payment Review Commission, the Prospective Pay-
23 ment Assessment Commission, and private expert
24 entities as appropriate.

1 “(6) CERTAIN PROVISIONS APPLICABLE.—Sec-
 2 tion 1845(c)(1) shall apply to the Commission in the
 3 same manner as it applies to the Physician Payment
 4 Review Commission.

5 “(7) AUTHORIZATION OF APPROPRIATIONS.—In
 6 addition to any amounts made available by the
 7 amendment made by subsection (b) of section 501 of
 8 the America’s Health Care Option Act, there are au-
 9 thorized to be appropriated such sums as may be
 10 necessary to carry out the provisions of this sub-
 11 section.”.

12 (b) CONFORMING AMENDMENT REPEALING THE
 13 COUNCIL ON GRADUATE MEDICAL EDUCATION.—Effec-
 14 tive October 1, 1995, section 30 of the Health Professions
 15 Extension Amendments of 1992 (Public Law 102-408) is
 16 repealed.

17 **SEC. 502. GRADUATE MEDICAL EDUCATION CONSORTIUM**
 18 **DEMONSTRATION PROJECTS.**

19 (a) IN GENERAL.—Section 1886 of the Social Secu-
 20 rity Act (42 U.S.C. 1395ww), as amended by section 501,
 21 is amended by adding at the end the following new sub-
 22 section:

23 “(k) CONSORTIUM DEMONSTRATION PROGRAM.—

24 “(1) IN GENERAL.—The Secretary, in consulta-
 25 tion with the Advisory Commission on Workforce

1 (established under subsection (j)), shall provide for
2 the establishment of demonstration projects for no
3 more than 10 health care training consortia which
4 are located in a State or are multi-State consortia
5 for the purpose of testing and evaluating mecha-
6 nisms to increase the number and percentage of
7 medical students entering primary care practice rel-
8 ative to those entering nonprimary care practice
9 through the use of funds otherwise available for di-
10 rect graduate medical education costs under sub-
11 section (h).

12 “(2) APPLICATIONS.—

13 “(A) IN GENERAL.—Each health care
14 training consortium desiring to conduct a dem-
15 onstration project under this subsection shall
16 prepare and submit to the Secretary an applica-
17 tion, at such time, in such manner, and con-
18 taining such information as the Secretary may
19 require, including an explanation of a plan for
20 evaluating the project.

21 “(B) APPROVAL OF APPLICATIONS.—A
22 consortium that submits an application under
23 subparagraph (A) may begin a demonstration
24 project under this subsection—

1 “(i) upon approval of such application
2 by the Secretary; or

3 “(ii) at the end of the 60-day period
4 beginning on the date such application is
5 submitted, unless the Secretary denies the
6 application during such period.

7 “(3) FUNDING FOR DEMONSTRATION
8 PROJECTS.—

9 “(A) ALLOCATION OF GME FUNDS.—

10 “(i) IN GENERAL.—For each year a
11 consortium conducts a demonstration
12 project under this subsection the Secretary
13 shall pay to such consortium an amount
14 equal to the total amount available to hos-
15 pitals that are members of the consortium
16 under subsection (h). The consortium shall
17 designate a teaching hospital for each resi-
18 dent assigned to the consortium which the
19 Secretary shall use to calculate the consor-
20 tium’s payment amount under such sec-
21 tion. Such teaching hospital shall be the
22 hospital where the resident receives the
23 majority of the resident’s hospital-based,
24 nonambulatory training experience.

1 “(ii) ADDITIONAL INCENTIVE PAY-
2 MENT.—For each year a consortium con-
3 ducts a demonstration project under this
4 subsection the Secretary shall also pay to
5 selected consortium an amount equal to an
6 incentive amount according to a formula to
7 be determined by the Secretary that would
8 allocate the amount made available pursu-
9 ant to subsection (d)(5)(B)(v) in such year
10 among the consortia conducting a dem-
11 onstration project under this subsection.

12 “(iii) USE OF FUNDS.—

13 “(I) TESTING AND EVALUA-
14 TION.—Each consortium that receives
15 a payment under clause (i) shall use
16 such funds to conduct activities which
17 test and evaluate mechanisms to in-
18 crease the number and percentage of
19 medical students entering primary
20 care practice relative to those entering
21 nonprimary care practice.

22 “(II) ESTABLISHMENT AND OP-
23 ERATION.—Each consortium that re-
24 ceives a payment under clause (i) may
25 also use such funds for the establish-

1 ment and operation of the consortium.
2 The Secretary shall make payments to
3 the consortium through an entity
4 identified by the consortium as appro-
5 priate for receiving payment on behalf
6 of the consortium. The consortium
7 shall have discretion in determining
8 the purposes for which such payments
9 may be used.

10 “(B) GRANTS FOR PLANNING AND EVAL-
11 UATIONS.—

12 “(i) IN GENERAL.—The Secretary
13 may award grants to consortia conducting
14 demonstration projects under this sub-
15 section for the purpose of developing and
16 evaluating such projects. Each consortium
17 desiring to receive a grant under this sub-
18 paragraph shall prepare and submit to the
19 Secretary an application, at such time, in
20 such manner, and containing such infor-
21 mation as the Secretary may require.

22 “(ii) AUTHORIZATION OF APPROPRIA-
23 TIONS.—There are authorized to be appro-
24 priated such sums as may be necessary to

1 carry out the purposes of this subpara-
2 graph for fiscal years 1995 through 2003.

3 “(4) MAINTENANCE OF EFFORT.—Any funds
4 available for the activities covered by a demonstra-
5 tion project conducted under this subsection shall
6 supplement, and shall not supplant, funds that are
7 expended for similar purposes under any State, re-
8 gional, or local program.

9 “(5) DURATION.—A demonstration project
10 under this subsection shall be conducted for a period
11 not to exceed 8 years. The Secretary may terminate
12 a project if the Secretary determines that the con-
13 sortium conducting the project is not in substantial
14 compliance with the terms of the application ap-
15 proved by the Secretary under this subsection.

16 “(6) EVALUATIONS AND REPORTS.—

17 “(A) EVALUATIONS.—Each consortium
18 that conducts a demonstration project under
19 this subsection shall submit to the Secretary
20 and the Advisory Commission on Workforce a
21 final evaluation of such project within 360 days
22 of the termination of such project and such in-
23 terim evaluations as the Secretary may require.

24 “(B) REPORTS TO CONGRESS.—Not later
25 than 360 days after the first demonstration

1 project under this subsection begins, and annu-
2 ally thereafter for each year in which a project
3 is conducted under this subsection, the Sec-
4 retary shall submit a report to the appropriate
5 committees of the Congress which evaluates the
6 effectiveness of the demonstration projects con-
7 ducted under this subsection and includes any
8 legislative recommendations determined appro-
9 priate by the Secretary.

10 “(7) DEFINITIONS.—For purposes of this sub-
11 section:

12 “(A) AMBULATORY TRAINING SITES.—The
13 term ‘ambulatory training sites’ includes, but is
14 not limited to, health maintenance organiza-
15 tions, federally qualified health centers, commu-
16 nity health centers, migrant health centers,
17 rural health clinics, nursing homes, hospice, and
18 other community-based providers, including pri-
19 vate practices.

20 “(B) HEALTH CARE TRAINING CONSOR-
21 TIUM.—The term ‘health care training consor-
22 tium’ includes a State, regional, or local entity
23 which—

24 “(i) includes, but is not limited to
25 partnerships of teaching hospitals, ambula-

1 tory training sites, and one or more schools
2 of medicine; and

3 “(ii) is operated in a manner intended
4 to ensure that by the end of the 8-year
5 demonstration project there will be an in-
6 crease in the number and percentage of
7 medical school students entering primary
8 care practice relative to those entering
9 nonprimary care practice.

10 “(C) PRIMARY CARE.—The term ‘primary
11 care’ means family practice, general internal
12 medicine, and general pediatrics, and obstetrics
13 and gynecology.”.

14 (b) SOURCE OF INCENTIVE PAYMENTS.—Section
15 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended
16 by adding at the end the following new clause:

17 “(v) For the purpose of making payments pur-
18 suant to subsection (k)(3)(A)(ii) for fiscal years
19 1996, 1997, 1998, 1999, and 2000, there shall be
20 available from the Federal Hospital Insurance Trust
21 Fund \$200,000,000 of the amount that would have
22 been expended under this subparagraph if the
23 amendments made by section 816 of the America’s
24 Health Care Option Act had not been in effect.”.

1 **SEC. 503. FUNDING UNDER MEDICARE FOR TRAINING IN**
2 **NONHOSPITAL-OWNED FACILITIES.**

3 (a) RESIDENCY TRAINING TIME IN NONHOSPITAL-
4 OWNED FACILITIES COUNTED IN DETERMINING FULL-
5 TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE
6 MEDICAL EDUCATION PAYMENTS.—Section
7 1886(h)(4)(E) of the Social Security Act (42 U.S.C.
8 1395ww(h)(4)(E)) is amended by striking “, if the hos-
9 pital incurs all, or substantially all, of the costs for the
10 training program in that setting”.

11 (b) RESIDENCY TRAINING TIME IN NONHOSPITAL-
12 OWNED FACILITIES COUNTED IN DETERMINING FULL-
13 TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL
14 EDUCATION PAYMENTS.—

15 (1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of
16 the Social Security Act (42 U.S.C.
17 1395ww(d)(5)(B)(iv)) is amended to read as follows:

18 “(iv) In determining such adjustment,
19 the Secretary shall—

20 “(I) count interns and residents
21 assigned to any patient service envi-
22 ronment which is part of the hos-
23 pital’s approved medical residency
24 training program (as defined in sub-
25 section (h)(5)(A)); and

1 “(II) count interns and residents
2 providing services at any entity receiv-
3 ing a grant under section 330 of the
4 Public Health Service Act that is
5 under the ownership or control of a
6 hospital (if the hospital incurs all, or
7 substantially all, of the costs of the
8 services furnished by such interns and
9 residents),
10 as part of the calculation of the full-time-
11 equivalent number of interns and resi-
12 dents.”.

13 (2) ADJUSTMENT OF INDIRECT TEACHING AD-
14 JUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRAL-
15 ITY.—Section 1886(d)(5)(B) of the Social Security
16 Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by
17 adding at the end the following new clause:

18 “(vi) The Secretary shall reduce all payments
19 under this subparagraph by such percentage as the
20 Secretary determines necessary so that, beginning on
21 the date of the enactment of the America’s Health
22 Care Option Act, the amendments made by section
23 503(b)(1) of such Act would not result in expendi-
24 tures under this subparagraph that exceed the

1 amount of such expenditures that would have been
 2 made if such amendments had not been made.”.

3 **SEC. 504. NATIONAL FUND FOR MEDICAL RESEARCH.**

4 (a) DESIGNATION OF OVERPAYMENTS AND CON-
 5 TRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL
 6 RESEARCH.—

7 (1) IN GENERAL.—Subchapter A of chapter 61
 8 of the Internal Revenue Code of 1986 (relating to
 9 returns and records) is amended by adding at the
 10 end the following new part:

11 **“PART IX—DESIGNATION OF OVERPAYMENTS**
 12 **AND CONTRIBUTIONS FOR THE NATIONAL**
 13 **FUND FOR MEDICAL RESEARCH**

“Sec. 6097. Amounts for the National Fund for Medical Research.

14 **“SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR MEDI-**
 15 **CAL RESEARCH.**

16 “(a) IN GENERAL.—Every individual (other than a
 17 nonresident alien) may designate that—

18 “(1) a portion (not less than \$1) of any over-
 19 payment of the tax imposed by chapter 1 for the
 20 taxable year, and

21 “(2) a cash contribution (not less than \$1),
 22 be paid over to the National Fund for Medical Research.
 23 In the case of a joint return of a husband and wife, each

1 spouse may designate one-half of any such overpayment
2 of tax (not less than \$2).

3 “(b) MANNER AND TIME OF DESIGNATION.—Any
4 designation under subsection (a) may be made with re-
5 spect to any taxable year only at the time of filing the
6 original return of the tax imposed by chapter 1 for such
7 taxable year. Such designation shall be made either on the
8 1st page of the return or on the page bearing the tax-
9 payer’s signature.

10 “(c) OVERPAYMENTS TREATED AS REFUNDED.—For
11 purposes of this section, any overpayment of tax des-
12 ignated under subsection (a) shall be treated as being re-
13 funded to the taxpayer as of the last day prescribed for
14 filing the return of tax imposed by chapter 1 (determined
15 with regard to extensions) or, if later, the date the return
16 is filed.

17 “(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—
18 No deduction shall be allowed under subtitle A with re-
19 spect to any amount designated pursuant to subsection (a)
20 for any taxable year.

21 “(e) TERMINATION.—This section shall not apply to
22 taxable years beginning in a calendar year after a deter-
23 mination by the Secretary that the sum of all designations
24 under subsection (a) for taxable years beginning in the

1 second and third calendar years preceding the calendar
2 year is less than \$5,000,000.”.

3 (2) CLERICAL AMENDMENT.—The table of
4 parts for subchapter A of chapter 61 of such Code
5 is amended by adding at the end the following new
6 item:

“Part IX. Designation of overpayments and contributions for the
National Fund for Medical Research.”.

7 (3) EFFECTIVE DATE.—The amendments made
8 by this subsection shall apply to taxable years begin-
9 ning after December 31, 1994.

10 (b) ESTABLISHMENT OF THE NATIONAL FUND FOR
11 MEDICAL RESEARCH.—

12 (1) IN GENERAL.—Subchapter A of chapter 98
13 of the Internal Revenue Code of 1986 (relating to
14 the trust fund code) is amended by adding at the
15 end the following new section:

16 **“SEC. 9512. NATIONAL FUND FOR MEDICAL RESEARCH.**

17 “(a) CREATION OF FUND.—There is established in
18 the Treasury of the United States a fund to be known
19 as the “National Fund for Medical Research”, consisting
20 of such amounts as may be credited or paid to such Fund
21 as provided in this section or section 9602(b).

22 “(b) TRANSFERS TO FUND.—There is hereby trans-
23 ferred to the National Fund for Medical Research
24 amounts equivalent to the amounts designated under sec-

1 tion 6097 (relating to designation of overpayments and
2 contributions to the Fund).

3 “(c) EXPENDITURES FROM FUND.—

4 “(1) IN GENERAL.—The Secretary shall pay an-
5 nually, within 30 days after the President signs an
6 appropriations Act for the Departments of labor,
7 Health and Human Services, and Education, and re-
8 lated agencies, or by the end of the first quarter of
9 the fiscal year, to the Secretary of Health and
10 Human Services on behalf of the National Institutes
11 of Health, an amount equal to the amount in the
12 National Fund for Medical Research at the time of
13 such payment, to carry out the purposes of section
14 404F of the Public Health Service Act, less any ad-
15 ministrative expenses which may be paid under para-
16 graph (2).

17 “(2) ADMINISTRATIVE EXPENSES.—Amounts in
18 the National Fund for Medical Research shall be
19 available to pay the administrative expenses of the
20 Department of the Treasury directly allocable to—

21 “(A) modifying the individual income tax
22 return forms to carry out section 6097,

23 “(B) carrying out this chapter with respect
24 to such Fund, and

1 “(C) processing amounts received under
2 section 6097 and transferring such amounts to
3 such Fund.

4 “(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—
5 The amounts in the National Fund for Medical Research
6 shall be excluded from, and shall not be taken into ac-
7 count, for purposes of any budget enforcement procedure
8 under the Congressional Budget Act of 1974 or the Bal-
9 anced Budget and Emergency Deficit Control Act of
10 1985.”.

11 (2) CLERICAL AMENDMENT.—The table of sec-
12 tions for subchapter A of chapter 98 of the Internal
13 Revenue Code of 1986 is amended by adding at the
14 end the following new item:

 “Sec. 9512. National Fund for Medical Research.”.

15 (c) PURPOSES FOR EXPENDITURES FROM FUND.—
16 Part A of title IV of the Public Health Service Act is
17 amended by adding at the end the following new section:

18 **“SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND**
19 **FOR MEDICAL RESEARCH.**

20 “(a) DISTRIBUTION OF AMOUNTS.—From amounts
21 received for any fiscal year from the National Fund for
22 Medical Research, the Secretary shall distribute—

23 “(1) 3 percent of such amounts to the Director
24 of NIH to be allocated at the Director’s discretion
25 for—

1 “(A) carrying out the responsibilities of the
2 Director of NIH, including the Office of Re-
3 search on Women’s Health, the Office of Re-
4 search on Minority Health, the Office on Alter-
5 native Medicine, and the Office of Rare Disease
6 Research;

7 “(B) construction of, and acquisition of
8 equipment for, facilities of or used by the Na-
9 tional Institutes of Health; and

10 “(C) transfer to the National Center for
11 Research Resources to carry out section 481A
12 concerning biomedical and behavioral research
13 facilities;

14 “(2) 1 percent of such amounts for carrying out
15 section 301 and part D of this title with respect to
16 health information communications; and

17 “(3) the remainder of such amounts to member
18 institutes and centers of the National Institutes of
19 Health in the same proportion to the total amount
20 received under this subsection, as the amount of an-
21 nual appropriations under appropriations Acts for
22 each member institute or center for the fiscal year
23 bears to the total amount of appropriations under
24 appropriations Acts for all member institutes and

1 centers of the National Institutes of Health for the
2 fiscal year.

3 “(b) PLANS OF ALLOCATION.—The amounts trans-
4 ferred under subsection (a) shall be allocated by the Direc-
5 tor of NIH or the various directors of the institutes and
6 centers, as the case may be, pursuant to allocation plans
7 developed by the various advisory councils to such direc-
8 tors, after consultation with such directors.

9 “(c) GRANTS AND CONTRACTS FULLY FUNDED IN
10 FIRST YEAR.—With respect to any grant or contract
11 funded by amounts distributed under subsection (a), the
12 full amount of the total obligation of such grant or con-
13 tract shall be funded in the first year of such grant or
14 contract, and shall remain available until expended.

15 “(d) MAINTENANCE OF EFFORT.—No amounts
16 transferred under subsection (a) shall replace or reduce
17 the amount of appropriations for the National Institutes
18 of Health under appropriations Acts.”.

19 **Subtitle B—Health Care Liability** 20 **Reform**

21 **SEC. 511. HEALTH CARE LIABILITY REFORM.**

22 (a) IN GENERAL.—Part A of subtitle A of title XI
23 of the Social Security Act (42 U.S.C. 1301 et seq.) is
24 amended by inserting after section 1128B the following
25 new section:

1 **“SEC. 1129. HEALTH CARE LIABILITY REFORM.**

2 “(a) DEFINITIONS.—As used in this section:

3 “(1) CLAIMANT.—The term ‘claimant’ means
4 any person who commences a health care liability ac-
5 tion, and any person on whose behalf such an action
6 is commenced, including the decedent in the case of
7 an action brought through or on behalf of an estate.

8 “(2) CLEAR AND CONVINCING EVIDENCE.—The
9 term ‘clear and convincing evidence’ is that measure
10 or degree of proof that will produce in the mind of
11 the trier of fact a firm belief or conviction as to the
12 truth of the allegations sought to be established, ex-
13 cept that such measure or degree of proof is more
14 than that required under preponderance of the evi-
15 dence, but less than that required for proof beyond
16 a reasonable doubt.

17 “(3) HEALTH CARE LIABILITY ACTION.—The
18 term “health care liability action” means a civil ac-
19 tion in a State or Federal court—

20 “(A) against a health care provider, health
21 care professional, or other defendant joined in
22 the action (regardless of the theory of liability
23 on which the action is based) in which the
24 claimant alleges injury related to the provision
25 of, or the failure to provide, health care serv-
26 ices; or

1 “(B) against a health care payor, a health
2 maintenance organization, insurance company,
3 or any other individual, organization, or entity
4 that provides payment for health care benefits
5 in which the claimant alleges that injury was
6 caused by the payment for, or the failure to
7 make payment for, health care benefits, except
8 to the extent such actions are subject to the
9 Employee Retirement Income Security Act of
10 1974.

11 “(3) HEALTH CARE PROFESSIONAL.—The term
12 ‘health care professional’ means any individual who
13 provides health care services in a State and who is
14 required by Federal or State laws or regulations to
15 be licensed, registered or certified to provide such
16 services or who is certified to provide health care
17 services pursuant to a program of education, train-
18 ing and examination by an accredited institution,
19 professional board, or professional organization.

20 “(4) HEALTH CARE PROVIDER.—The term
21 ‘health care provider’ means any organization or in-
22 stitution that is engaged in the delivery of health
23 care services in a State and that is required by Fed-
24 eral or State laws or regulations to be licensed, reg-

1 istered or certified to engage in the delivery of such
2 services.

3 “(5) HEALTH CARE SERVICES.—The term
4 ‘health care services’ means any services provided by
5 a health care professional or health care provider, or
6 any individual working under the supervision of a
7 health care professional, that relate to the diagnosis,
8 prevention, or treatment of any disease or impair-
9 ment, or the assessment of the health of human
10 beings.

11 “(6) INJURY.—The term ‘injury’ means any ill-
12 ness, disease, or other harm that is the subject of
13 a health care liability action.

14 “(7) NONECONOMIC LOSSES.—The term ‘non-
15 economic losses’ means losses for physical and emo-
16 tional pain, suffering, inconvenience, physical im-
17 pairment, mental anguish, disfigurement, loss of en-
18 joyment of life, loss of consortium, and other
19 nonpecuniary losses incurred by an individual with
20 respect to which a health care liability action is
21 brought.

22 “(8) PUNITIVE DAMAGES.—The term ‘punitive
23 damages’ means damages awarded, for the purpose
24 of punishment or deterrence, and not for compen-
25 satory purposes, against a health care provider,

1 health care organization, or other defendant in a
2 health care liability action. Punitive damages are
3 neither economic nor noneconomic damages.

4 “(b) APPLICABILITY.—

5 “(1) IN GENERAL.—Except as provided in para-
6 graph (3), this section shall apply with respect to
7 any health care liability action brought in any Fed-
8 eral or State court, except that this section shall not
9 apply to an action for damages arising from a vac-
10 cine-related injury or death to the extent that title
11 XXI of the Public Health Service Act applies to the
12 action.

13 “(2) PREEMPTION.—The provisions of this sec-
14 tion shall preempt any State law to the extent such
15 law is inconsistent with the limitations contained in
16 such provisions. The provisions of this section shall
17 not preempt any State law that—

18 “(A) provides for defenses in addition to
19 those contained in this section, places greater
20 limitations on the amount of attorneys’ fees
21 that can be collected, or otherwise imposes
22 greater restrictions on non-economic or punitive
23 damages than those provided in this section;

1 “(B) permits State officials to commence
2 health care liability actions as a representative
3 of an individual; or

4 “(C) permits provider-based dispute resolu-
5 tion.

6 “(3) EFFECT ON SOVEREIGN IMMUNITY AND
7 CHOICE OF LAW OR VENUE.—Nothing in this section
8 shall be construed to—

9 “(A) waive or affect any defense of sov-
10 ereign immunity asserted by any State under
11 any provision of law;

12 “(B) waive or affect any defense of sov-
13 ereign immunity asserted by the United States;

14 “(C) affect the applicability of any provi-
15 sion of the Foreign Sovereign Immunities Act
16 of 1976;

17 “(D) preempt State choice-of-law rules
18 with respect to actions brought by a foreign na-
19 tion or a citizen of a foreign nation; or

20 “(E) affect the right of any court to trans-
21 fer venue or to apply the law of a foreign nation
22 or to dismiss an action of a foreign nation or
23 of a citizen of a foreign nation on the ground
24 of inconvenient forum.

1 “(4) FEDERAL COURT JURISDICTION NOT ES-
2 TABLISHED ON FEDERAL QUESTION GROUNDS.—
3 Nothing in this section shall be construed to estab-
4 lish any jurisdiction in the district courts of the
5 United States over health care liability actions on
6 the basis of sections 1331 or 1337 of title 28, Unit-
7 ed States Code.

8 “(c) STATUTE OF LIMITATIONS.—

9 “(1) IN GENERAL.—Except as provided in para-
10 graph (2), no health care liability action may be ini-
11 tiated after the expiration of the 2-year period that
12 begins on the date on which the alleged injury and
13 its cause should reasonably have been discovered,
14 but in no event later than 5 years after the date of
15 the alleged occurrence of the injury.

16 “(2) EXCEPTION FOR MINORS.—In the case of
17 an alleged injury suffered by a minor who has not
18 attained 6 years of age, no health care liability ac-
19 tion may be initiated after the expiration of the 2-
20 year period that begins on the date on which the al-
21 leged injury and its cause should reasonably have
22 been discovered, but in no event later than 6 years
23 after the date of the alleged occurrence of the injury
24 and its cause or the date on which the minor attains
25 11 years of age, whichever is later.

1 “(d) REFORM OF NONECONOMIC DAMAGES.—

2 “(1) IN GENERAL.—With respect to a health
3 care liability action brought in any forum, the total
4 amount of damages that may be awarded to an indi-
5 vidual and the family members of such individual for
6 noneconomic losses resulting from an injury alleged
7 under such action may not exceed \$250,000, regard-
8 less of the number of health care professionals,
9 health care providers, and other defendants against
10 whom the action is brought or the number of actions
11 brought with respect to the injury. If the jury’s
12 damage award exceeds such limitation, a reduction
13 in such award shall be made by the court.

14 “(2) STUDY.—The Secretary, in consultation
15 with the Attorney General, shall conduct a study to
16 determine an appropriate schedule with respect to
17 an increase in the limitation described in paragraph
18 (1) in years subsequent to the calendar year in
19 which this section is enacted. Not later than Janu-
20 ary 1, 1997, the Secretary shall submit such a
21 schedule to Congress.

22 “(3) JOINT RESOLUTION AND CONSIDERATION
23 BY CONGRESS.—

24 “(A) IN GENERAL.—The schedule under
25 paragraph (2) shall be implemented unless a

1 joint resolution (described in subparagraph (B))
2 disapproving such recommendations is enacted
3 in accordance with the provisions of subpara-
4 graph (C), before the end of the 45-day period
5 beginning on the date on which such schedule
6 was submitted. For purposes of applying the
7 preceding sentence and subparagraphs (B) and
8 (C), the days on which either House of Con-
9 gress is not in session because of an adjourn-
10 ment of more than three days to a day certain
11 shall be excluded in the computation of a pe-
12 riod.

13 “(B) JOINT RESOLUTION OF DIS-
14 APPROVAL.—A joint resolution described in this
15 subparagraph means only a joint resolution
16 which is introduced within the 10-day period
17 beginning on the date on which the Secretary
18 submits the schedule under paragraph (2)
19 and—

20 “(i) which does not have a preamble;

21 “(ii) the matter after the resolving
22 clause of which is as follows: “That Con-
23 gress disapproves the schedule of the Sec-
24 retary of Health and Human Services con-
25 cerning adjustments in limitations on non-

1 economic damages with respect to health
2 care liability actions, as submitted by the
3 Secretary on _____.”, the blank
4 space being filled in with the appropriate
5 date; and

6 “(iii) the title of which is as follows:
7 “Joint resolution disapproving the schedule
8 of the Secretary of Health and Human
9 Services concerning adjustments in limita-
10 tions on noneconomic damages with re-
11 spect to health care liability actions, as
12 submitted by the Secretary on
13 _____.”, the blank space being
14 filled in with the appropriate date.

15 “(C) PROCEDURES FOR CONSIDERATION
16 OF RESOLUTION OF DISAPPROVAL.—Subject to
17 subparagraph (D), the provisions of section
18 2908 (other than subsection (a)) of the Defense
19 Base Closure and Realignment Act of 1990
20 shall apply to the consideration of a joint reso-
21 lution described in subparagraph (B) in the
22 same manner as such provisions apply to a joint
23 resolution described in section 2908(a) of such
24 Act.

1 “(D) SPECIAL RULES.—For purposes of
2 applying subparagraph (C) with respect to such
3 provisions—

4 “(i) any reference to the Committee
5 on Armed Services of the House of Rep-
6 resentatives shall be deemed a reference to
7 an appropriate Committee of the House of
8 Representatives (specified by the Speaker
9 of the House of Representatives at the
10 time of submission of recommendations
11 under paragraph (1)) and any reference to
12 the Committee on Armed Services of the
13 Senate shall be deemed a reference to an
14 appropriate Committee of the Senate
15 (specified by the Majority Leader of the
16 Senate at the time of submission of rec-
17 ommendations under paragraph (1)); and

18 “(ii) any reference to the date on
19 which the President transmits a report
20 shall be deemed a reference to the date on
21 which the Secretary submits a rec-
22 ommendation under paragraph (1).

23 “(e) REFORM OF PUNITIVE DAMAGES.—

24 “(1) LIMITATION.—With respect to a health
25 care liability action, an award for punitive damages

1 may only be made, if otherwise permitted by applica-
2 ble law, if it is proven by clear and convincing evi-
3 dence—

4 “(A) that the defendant intended to injure
5 the claimant for a reason unrelated to the pro-
6 vision of health care services;

7 “(B) that the defendant understood the
8 claimant was substantially certain to suffer un-
9 necessary injury, yet the defendant in providing
10 or failing to provide health care services, delib-
11 erately failed to avoid such injury; or

12 “(C) that the defendant acted with a con-
13 scious disregard of a substantial and unjustifi-
14 able risk of unnecessary injury which the de-
15 fendant failed to avoid in a manner which con-
16 stitutes a gross deviation from the normal
17 standard of conduct in such circumstances.

18 “(2) PUNITIVE DAMAGES NOT PERMITTED.—
19 Notwithstanding the provisions of paragraph (1),
20 punitive damages may not be awarded against a de-
21 fendant with respect to any health care liability ac-
22 tion if—

23 “(A) no judgment for compensatory dam-
24 ages, including nominal damages (under \$500),
25 is rendered against the defendant; or

1 “(B) the underlying health care liability
2 action arises out of the same act or course of
3 conduct by the defendant that resulted in a
4 prior award of punitive damages to any individ-
5 ual.

6 “(3) REQUIREMENTS FOR PLEADING OF PUNI-
7 TIVE DAMAGES.—

8 “(A) IN GENERAL.—The claimant’s com-
9 plaint or initial pleading in any health care li-
10 ability action may not include a demand for pu-
11 nitive damages.

12 “(B) AMENDED PLEADING.—A court may
13 allow a claimant to file an amended complaint
14 or pleading for punitive damages if—

15 “(i) the claimant submits a motion to
16 amend the complaint or pleading within
17 the earlier of—

18 “(I) 2 years after the complaint
19 or initial pleading is filed, or

20 “(II) 9 months before the date
21 the matter is first set for trial; and

22 “(ii) after a finding by a court upon
23 review of supporting and opposing affida-
24 vits or after a hearing, that after weighing
25 the evidence the claimant has established

1 by a substantial probability that the claim-
2 ant will prevail on the claim for punitive
3 damages.

4 “(4) SEPARATE PROCEEDING.—

5 “(A) IN GENERAL.—At the request of any
6 defendant in a health care liability action, the
7 trier of fact shall consider in a separate pro-
8 ceeding—

9 “(i) whether punitive damages are to
10 be awarded and the amount of such award,
11 or

12 “(ii) the amount of punitive damages
13 following a determination of punitive liabil-
14 ity.

15 “(B) ONLY RELEVANT EVIDENCE ADMISSI-
16 BLE.—If a defendant requests a separate pro-
17 ceeding under subparagraph (A), evidence rel-
18 evant only to the claim of punitive damages, as
19 determined by applicable State law, shall be in-
20 admissible in any proceeding to determine
21 whether compensatory damages are to be
22 awarded.

23 “(5) DETERMINING AMOUNT OF PUNITIVE DAM-
24 AGES.—

1 “(A) IN GENERAL.—In determining the
2 amount of punitive damages, the trier of fact
3 shall consider only the following:

4 “(i) The severity of the harm caused
5 by the conduct of the defendant.

6 “(ii) The duration of the conduct or
7 any concealment of it by the defendant.

8 “(iii) The profitability of the conduct
9 of the defendant.

10 “(iv) The number of products sold or
11 medical procedures rendered for compensa-
12 tion, as the case may be, by the defendant
13 of the kind causing the harm complained
14 of by the claimant.

15 “(v) Awards of punitive or exemplary
16 damages to persons similarly situated to
17 the claimant, when offered by the defend-
18 ant.

19 “(vi) Prospective awards of compen-
20 satory damages to persons similarly situ-
21 ated to the claimant.

22 “(vii) Any criminal penalties imposed
23 on the defendant as a result of the conduct
24 complained of by the claimant, when of-
25 fered by the defendant.

1 “(viii) The amount of any civil fines
2 assessed against the defendant as a result
3 of the conduct complained of by the claim-
4 ant, when offered by the defendant.

5 “(B) LIMITATION ON AMOUNT OF PUNI-
6 TIVE DAMAGES.—In no event shall the amount
7 of punitive damages awarded exceed the lesser
8 of 2 times the amount of compensatory dam-
9 ages awarded or \$500,000. The jury shall not
10 be informed of this limitation.

11 “(6) RESTRICTIONS PERMITTED.—Nothing in
12 this section shall be construed to imply a right to
13 seek punitive damages where none exists under Fed-
14 eral or State law.

15 “(7) HEALTH CARE QUALITY ASSURANCE PRO-
16 GRAM.—

17 “(A) FUND.—Each participating State
18 shall establish a health care quality assurance
19 program, to be approved by the Secretary, and
20 a fund consisting of such amounts as are trans-
21 ferred to the fund under subparagraph (B).

22 “(B) TRANSFER OF AMOUNTS.—Each par-
23 ticipating State shall require that 50 percent of
24 all awards of punitive damages resulting from
25 all health care liability actions in that State be

1 transferred to the fund established under sub-
2 paragraph (B) in the State.

3 “(C) OBLIGATIONS FROM FUND.—The
4 chief executive officer of a participating State
5 shall obligate such sums as are available in the
6 fund established in that State under subpara-
7 graph (A) to—

8 “(A) license and certify health care profes-
9 sionals in the State;

10 “(B) implement health care quality assur-
11 ance programs; and

12 “(C) carry out programs to reduce mal-
13 practice-related costs for health care providers
14 volunteering to provide health care services in
15 medically underserved areas.

16 “(f) PERIODIC PAYMENTS.—With respect to a health
17 care liability action, no person may be required to pay
18 more than \$100,000 for future damages in a single pay-
19 ment of a damages award, but a person shall be permitted
20 to make such payments of the award on a periodic basis.
21 The periods for such payments shall be determined by the
22 adjudicating body, based upon projections of future losses
23 and shall be reduced to present value. The adjudicating
24 body may waive the requirements of this subsection if such

1 body determines that such a waiver is in the interests of
2 justice.

3 “(g) SCOPE OF LIABILITY.—

4 “(1) IN GENERAL.—With respect to punitive
5 and noneconomic damages, the liability of each de-
6 fendant in a health care liability action shall be sev-
7 eral only and may not be joint. Such a defendant
8 shall be liable only for the amount of punitive or
9 noneconomic damages allocated to the defendant in
10 direct proportion to such defendant’s percentage of
11 fault or responsibility for the injury suffered by the
12 claimant.

13 “(2) DETERMINATION OF PERCENTAGE OF LI-
14 ABILITY.—The trier of fact in a health care liability
15 action shall determine the extent of each defendant’s
16 fault or responsibility for injury suffered by the
17 claimant, and shall assign a percentage of respon-
18 sibility for such injury to each such defendant.

19 “(3) PROHIBITION ON VICARIOUS LIABILITY.—
20 A defendant in a health care liability action may not
21 be held vicariously liable for the direct actions or
22 omissions of other individuals.

23 “(h) MANDATORY OFFSETS FOR DAMAGES PAID BY
24 A COLLATERAL SOURCE.—

1 “(1) IN GENERAL.—With respect to a health
2 care liability action, the total amount of damages re-
3 ceived by an individual under such action shall be
4 reduced, in accordance with paragraph (2), by any
5 other payment that has been, or will be, made to an
6 individual to compensate such individual for the in-
7 jury that was the subject of such action.

8 “(2) AMOUNT OF REDUCTION.—The amount by
9 which an award of damages to an individual for an
10 injury shall be reduced under paragraph (1) shall
11 be—

12 “(A) the total amount of any payments
13 (other than such award) that have been made
14 or that will be made to such individual to pay
15 costs of or compensate such individual for the
16 injury that was the subject of the action; minus

17 “(B) the amount paid by such individual
18 (or by the spouse, parent, or legal guardian of
19 such individual) to secure the payments de-
20 scribed in subparagraph (A) and any portion of
21 the award subject to a subrogation lien or
22 claim.

23 “(i) TREATMENT OF ATTORNEYS’ FEES AND OTHER
24 COSTS.—

1 “(1) LIMITATION ON AMOUNT OF CONTINGENCY
2 FEES.—

3 “(A) IN GENERAL.—An attorney who rep-
4 represents, on a contingency fee basis, a claimant
5 in a health care liability action may not charge,
6 demand, receive, or collect for services rendered
7 in connection with such action in excess of the
8 following amount recovered by judgment or set-
9 tlement under such action:

10 “(i) $33\frac{1}{3}$ percent of the first
11 \$150,000 (or portion thereof) recovered,
12 based on after-tax recovery, plus

13 “(ii) 25 percent of any amount in ex-
14 cess of \$150,000 recovered, based on after-
15 tax recovery.

16 “(B) CALCULATION OF PERIODIC PAY-
17 MENTS.—In the event that a judgment or set-
18 tlement includes periodic or future payments of
19 damages, the amount recovered for purposes of
20 computing the limitation on the contingency fee
21 under subparagraph (A) shall be based on the
22 cost of the annuity or trust established to make
23 the payments. In any case in which an annuity
24 or trust is not established to make such pay-

1 ments, such amount shall be based on the
2 present value of the payments.

3 “(3) CONTINGENCY FEE DEFINED.—As used in
4 this subsection, the term ‘contingency fee’ means
5 any fee for professional legal services which is, in
6 whole or in part, contingent upon the recovery of
7 any amount of damages, whether through judgment
8 or settlement.

9 “(j) OBSTETRIC CASES.—With respect to a health
10 care liability action relating to services provided during
11 labor or the delivery of a baby, if the health care profes-
12 sional against whom the action is brought did not pre-
13 viously treat the pregnant woman for the pregnancy, the
14 trier of fact may not find that the defendant committed
15 malpractice and may not assess damages against the
16 health care professional unless the malpractice is proven
17 by clear and convincing evidence.

18 “(k) REQUIREMENTS FOR RISK MANAGEMENT PRO-
19 GRAMS.—

20 “(1) REQUIREMENTS FOR PROVIDERS.—Each
21 State shall require each health care professional and
22 health care provider providing services in the State
23 to participate in a risk management program to pre-
24 vent and provide early warning of practices which

1 may result in injuries to patients or which otherwise
2 may endanger patient safety.

3 “(2) REQUIREMENTS FOR INSURERS.—Each
4 State shall require each entity which provides health
5 care professional or provider liability insurance to
6 health care professionals and health care providers
7 in the State to—

8 “(A) establish risk management programs
9 based on data available to such entity or sanc-
10 tion programs of risk management for health
11 care professionals and health care providers
12 provided by other entities; and

13 “(B) require each such professional or pro-
14 vider, as a condition of maintaining insurance,
15 to participate in one program described in sub-
16 paragraph (A) at least once in each 3-year pe-
17 riod.

18 “(l) PERMITTING STATE PROFESSIONAL SOCIETIES
19 TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.—

20 “(1) ROLE OF PROFESSIONAL SOCIETIES.—
21 Notwithstanding any other provision of State or
22 Federal law, a State agency responsible for the con-
23 duct of disciplinary actions for a type of health care
24 provider may enter into agreements with State or
25 county professional societies of such type of health

1 care professional to permit such societies to partici-
2 pate in the licensing of such health care professional,
3 and to review any health care liability action, health
4 care liability allegation, or other information con-
5 cerning the practice patterns of any such health care
6 professional. Any such agreement shall comply with
7 paragraph (2).

8 “(2) REQUIREMENTS OF AGREEMENTS.—Any
9 agreement entered into under paragraph (1) for li-
10 censing activities or the review of any health care li-
11 ability action, health care liability allegation, or
12 other information concerning the practice patterns
13 of a health care professional shall provide that—

14 “(A) the health care professional society
15 conducts such activities or review as expedi-
16 tiously as possible;

17 “(B) after the completion of such review,
18 such society shall report its findings to the
19 State agency with which it entered into such
20 agreement;

21 “(C) the conduct of such activities or re-
22 view and the reporting of such findings be con-
23 ducted in a manner which assures the preserva-
24 tion of confidentiality of health care information
25 and of the review process; and

1 “(D) no individual affiliated with such so-
 2 ciety is liable for any damages or injury directly
 3 caused by the individual’s actions in conducting
 4 such activities or review.

5 “(3) AGREEMENTS NOT MANDATORY.—Nothing
 6 in this subsection may be construed to require a
 7 State to enter into agreements with societies de-
 8 scribed in paragraph (1) to conduct the activities de-
 9 scribed in such paragraph.

10 “(4) EFFECT OF AGREEMENT.—

11 (b) EFFECTIVE DATE.—The amendment made by
 12 subsection (a) shall apply to health care liability actions
 13 arising on or after January 1, 1995.

14 **Subtitle C—Health Care Antitrust** 15 **Improvements**

16 **SEC. 521. PROTECTION FROM ANTITRUST LAWS FOR CER-** 17 **TAIN COMPETITIVE AND COLLABORATIVE** 18 **ACTIVITIES.**

19 (a) PROTECTIONS DESCRIBED.—An activity relating
 20 to the provision of health care services shall receive the
 21 following protection from the antitrust laws:

22 (1) If the activity is within a safe harbor des-
 23 ignated by the Attorney General under section 522,
 24 the safe harbor shall be a defense to all antitrust
 25 claims, except for claims for injunctive relief as-

1 serted by the Attorney General or the Chair in ex-
2 traordinary circumstances.

3 (2) If the activity is specified in and in compli-
4 ance with the terms of a certificate of review issued
5 by the Attorney General under section 523 and the
6 activity occurs while the certificate is in effect, the
7 certificate shall be a defense to antitrust claims,
8 other than claims for injunctive relief.

9 (b) AWARD OF ATTORNEY'S FEES AND COSTS OF
10 SUIT.—

11 (1) IN GENERAL.—If any person brings an ac-
12 tion alleging a claim under the antitrust laws and
13 the activity on which the claim is based is found by
14 the court to be protected from such laws under sub-
15 section (a), the court shall, at the conclusion of the
16 action—

17 (A) award to a substantially prevailing
18 claimant the cost of suit attributable to such
19 claim, including a reasonable attorney's fee, or

20 (B) award to a substantially prevailing
21 party defending against such claim the cost of
22 such suit attributable to such claim, including
23 reasonable attorney's fee, if the claim, or the
24 claimant's conduct during litigation of the

1 claim, was frivolous, unreasonable, without
2 foundation, or in bad faith.

3 (2) OFFSET IN CASES OF BAD FAITH.—The
4 court may reduce an award made pursuant to para-
5 graph (1) in whole or in part by an award in favor
6 of another party for any part of the cost of suit (in-
7 cluding a reasonable attorney's fee) attributable to
8 conduct during the litigation by any prevailing party
9 that the court finds to be frivolous, unreasonable,
10 without foundation, or in bad faith.

11 **SEC. 522. DESIGNATION OF SAFE HARBORS.**

12 (a) IN GENERAL.—

13 (1) DESIGNATION BY ATTORNEY GENERAL.—
14 The Attorney General, in consultation with the Sec-
15 retary and the Chair, shall develop and designate
16 pursuant to paragraph (C) safe harbors for purposes
17 of section 521(a)(1) relating to—

18 (A) each category of activities referred to
19 in paragraph (2); and

20 (B) such other categories of activities as
21 the Attorney General may designate in accord-
22 ance with the process described in this section.

23 (2) REQUIRED CATEGORIES OF ACTIVITIES SUB-
24 JECT TO SAFE HARBORS.—The categories of activi-
25 ties referred to in this paragraph are as follows:

1 (A) JOINT PURCHASING OF HEALTH CARE
2 SERVICES.—Providing the terms under which
3 consumers of health care services (patients or
4 others acting on their behalf) may jointly nego-
5 tiate and purchase health care services.

6 (B) SMALL HOSPITAL MERGERS.—Provid-
7 ing for small hospitals lawfully to merge under
8 the antitrust laws without undue delay or re-
9 view, taking into account the special needs and
10 circumstances of rural health care markets.

11 (C) NETWORK FORMATION AND OPER-
12 ATION.—Permitting activities related to the
13 startup and operation of collaborations between
14 State-licensed providers through partial or full
15 integration, including multi-provider networks,
16 hospital networks, physician-hospital organiza-
17 tions, and other efforts to provide health care
18 services more efficiently.

19 (D) ACTIVITIES OF MEDICAL SELF-REGU-
20 LATORY ENTITIES.—Permitting standard set-
21 ting and enforcement activities by medical self-
22 regulatory entities (such as hospital boards and
23 medical societies) to promote health care qual-
24 ity, except that a safe harbor under this para-
25 graph may not provide protection for any activ-

1 ity undertaken for financial gain or for anti-
2 competitive reasons.

3 (E) PROVISION OF INFORMATION TO BUY-
4 ERS AND CONSUMERS.—Permitting health care
5 providers collectively to supply non-price medi-
6 cal information to buyers and consumers relat-
7 ing to the type, quality and efficiency of treat-
8 ment, including joint views on procedures that
9 should be covered by purchasers and medical
10 protocols, except that a safe harbor under this
11 subparagraph may not provide protection for
12 any collective refusals to deal or collective at-
13 tempts at coercion.

14 (F) PARTICIPATION IN SURVEYS.—Provid-
15 ing the terms under which health care providers
16 may lawfully participate in written surveys of
17 prices of services, reimbursements received, em-
18 ployee compensation, and other relevant areas.

19 (G) HIGH-TECHNOLOGY AND TERTIARY
20 CARE JOINT VENTURES.—Permitting activities
21 of health care joint ventures to purchase or use
22 new or existing high technology or costly equip-
23 ment, or to provide advanced tertiary care serv-
24 ices.

1 (H) MARKET POWER SCREENS.—Providing
2 market power screens at appropriate levels
3 below which combinations of health care provid-
4 ers are too small to pose a realistic antitrust
5 threat. There may be different levels for dif-
6 ferent activities and markets, taking into ac-
7 count the special needs of rural health care
8 markets.

9 (I) JOINT PURCHASING ARRANGEMENTS.—
10 Providing the terms under which health care
11 providers may make joint purchases of products
12 and services.

13 (J) GOOD FAITH NEGOTIATIONS.—Provid-
14 ing the terms under which health care providers
15 may engage in discussions relating to legitimate
16 collaborative activities contemplated by the safe
17 harbors.

18 (b) PROCESS FOR DESIGNATION OF ADDITIONAL
19 CATEGORIES OF ACTIVITIES.—

20 (1) SOLICITATION OF PROPOSALS.—Not later
21 than 30 days after the date of the enactment of this
22 Act, the Attorney General shall publish a notice in
23 the Federal Register soliciting proposals for safe
24 harbors.

1 (2) REVIEW OF PROPOSED SAFE HARBORS.—

2 Not later than 180 days after the date of the enact-
3 ment of this Act, the Attorney General (in consulta-
4 tion with the Secretary and the Chair) shall review
5 the proposed safe harbors submitted under para-
6 graph (1) and include a description of the safe har-
7 bors in the report under subsection (d).

8 (3) ADDITIONAL SAFE HARBORS.—After sub-
9 mitting the report under subsection (d), the Attor-
10 ney General (in consultation with the Secretary and
11 the Chair) may from time to time add additional
12 safe harbors in accordance with the procedures de-
13 scribed in this subsection.

14 (c) EFFECTIVE DATE OF SAFE HARBORS.—

15 (1) PUBLICATION.—Not later than 180 days
16 after the date of the enactment of this Act, the At-
17 torney General shall publish in the Federal Register
18 for public comment the safe harbors proposed for
19 designation under this section. Not later than 180
20 days after publishing such proposed safe harbors in
21 the Federal Register, the Attorney General shall
22 issue final rules establishing such safe harbors.

23 (2) EFFECTIVE DATE.—The safe harbors estab-
24 lished under the final rules issued under paragraph

1 (1) shall take effect 90 days after issuance, unless
2 disapproved by the Congress.

3 (d) REPORT ON PROPOSED SAFE HARBORS.—Not
4 later than 180 days after the date of the enactment of
5 this Act, the Attorney General (in consultation with the
6 Secretary and the Chair) shall submit a report to Congress
7 describing the proposals from subsections (a) and (b)(1)
8 to be included in the publication of safe harbors described
9 in subsection (c)(1) and the proposals from subsection
10 (b)(1) that are not to be so included, together with expla-
11 nations therefor.

12 (e) MODIFICATION OR REMOVAL OF SAFE HAR-
13 BORS.—The Attorney General (in consultation with the
14 Secretary and the Chair) may modify or remove a safe
15 harbor following notice and comment upon a determina-
16 tion that the safe harbor does not meet the criteria of sub-
17 section (f).

18 (f) CRITERIA FOR SAFE HARBORS.—In establishing
19 safe harbors under this section, the Attorney General shall
20 take into account the following:

21 (1) The extent to which a competitive or col-
22 laborative activity will accomplish any of the follow-
23 ing:

24 (A) An increase in access to health care
25 services.

1 (B) The enhancement of the quality of
2 health care services.

3 (C) The establishment of cost efficiencies
4 that will be passed on to consumers, including
5 economies of scale and reduced transaction and
6 administrative costs.

7 (D) An increase in the ability of health
8 care facilities to provide services in medically
9 underserved areas or to medically underserved
10 populations.

11 (E) An improvement in the utilization of
12 health care resources or the reduction in the in-
13 efficient duplication of the use of such re-
14 sources.

15 (2) Whether the designation of an activity as a
16 safe harbor will result in the following outcomes:

17 (A) Health plans and other health care in-
18 surers, consumers of health care services, and
19 health care providers will be better able to ne-
20 gotiate payment and service arrangements
21 which will reduce costs to consumers.

22 (B) Taking into consideration the charac-
23 teristics of the particular purchasers and pro-
24 viders involved, competition will not be unduly
25 restricted.

1 (C) Equally efficient and less restrictive al-
2 ternatives do not exist to meet the criteria de-
3 scribed in paragraph (1).

4 (D) The activity will not unreasonably
5 foreclose competition by denying competitors a
6 necessary element of competition.

7 **SEC. 523. CERTIFICATES OF REVIEW.**

8 (a) ESTABLISHMENT OF PROGRAM.—In consultation
9 with the Secretary and the Chair, the Attorney General
10 shall (not later than 180 days after the date of the enact-
11 ment of this Act) issue certificates of review in accordance
12 with this section for providers of health care services and
13 advise and assist any person with respect to applying for
14 such a certificate of review.

15 (b) PROCEDURES FOR APPLICATION FOR CERTIFI-
16 CATE.—

17 (1) SUBMISSION OF APPLICATION.—

18 (A) FORM; CONTENT.—To apply for a cer-
19 tificate of review, a person shall submit to the
20 Attorney General a written application which—

21 (i) specifies the activities relating to
22 the provision of health care services which
23 satisfy the criteria described in section
24 522(f) and which will be included in the
25 certificate; and

1 (ii) is in a form and contains any in-
2 formation, including information pertain-
3 ing to the overall market in which the ap-
4 plicant operates, required by rule or regu-
5 lation promulgated under section 526.

6 (B) FILING FEE.—The Attorney General
7 may require a filing fee to be submitted with
8 the application to cover the cost of publication
9 and the cost of review required by this section.
10 The amount of the filing fee shall be deter-
11 mined on a sliding scale established by the At-
12 torney General in consultation with the Chair
13 (based on the monetary size of the transaction
14 involved), except that such fee may not exceed
15 \$5,000.

16 (2) PUBLICATION OF NOTICE IN FEDERAL REG-
17 ISTER.—Within 10 days after an application submit-
18 ted under paragraph (1) is received by the Attorney
19 General, the Attorney General shall publish in the
20 Federal Register a notice that announces that an
21 application for a certificate of review has been sub-
22 mitted, identifies each person submitting the appli-
23 cation, and describes the conduct for which the ap-
24 plication is submitted.

1 (3) ESTABLISHMENT OF PROCEDURES FOR IS-
2 SUANCE OF CERTIFICATE.—In consultation with the
3 Chair and the Secretary, the Attorney General shall
4 establish procedures to be used in applying for and
5 in determining whether to approve an application for
6 a certificate of review under this subtitle. Under
7 such procedures the Attorney General, in consulta-
8 tion with the Secretary, shall approve an application
9 if the Attorney General determines that the activities
10 to be covered under the certificate will satisfy the
11 criteria described in section 522(f) for safe harbors
12 designated under such section and that the benefits
13 of the issuance of the certificate will outweigh any
14 disadvantages that may result from reduced com-
15 petition. If the Attorney General, with the concur-
16 rence of the Secretary, determines that the require-
17 ments for a certificate are met, the Attorney General
18 shall issue to the applicant a certificate of review.
19 The certificate of review shall specify—
20 (i) the health care market activities to
21 which the certificate applies,
22 (ii) the person to whom the certificate
23 of review is issued, and
24 (iii) any terms and conditions the At-
25 torney General or the Secretary deems nec-

1 necessary to assure compliance with the appli-
2 cable procedures described in paragraph
3 (3).

4 (4) TIMING FOR DECISION ON APPLICATION.—
5 Within 90 days after the Attorney General receives
6 an application for a certificate of review, the Attor-
7 ney General shall determine whether to grant or
8 deny the certificate.

9 (5) NOTIFICATION OF DECISION.—The Attor-
10 ney General shall notify the applicant of the Attor-
11 ney General's determination and, if the application
12 is denied, the reasons for the denial.

13 (6) FRAUDULENT PROCUREMENT.—A certifi-
14 cate of review shall be void ab initio with respect to
15 any health care market activities for which the cer-
16 tificate was procured by fraud.

17 (c) AMENDMENT AND REVOCATION OF CERTIFI-
18 CATES.—

19 (1) NOTIFICATION OF CHANGES.—Any appli-
20 cant who receives a certificate of review—

21 (A) shall promptly report to the Attorney
22 General any change relevant to the matters
23 specified in the certificate; and

24 (B) may submit to the Attorney General
25 an application to amend the certificate to re-

1 flect the effect of the change on the conduct
2 specified in the certificate.

3 (2) AMENDMENT TO CERTIFICATE.—An appli-
4 cation for an amendment to a certificate of review
5 shall be treated as an application for the issuance of
6 a certificate. The effective date of an amendment
7 shall be the date on which the application for the
8 amendment is received by the Attorney General.

9 (3) REVOCATION.—

10 (A) GROUNDS FOR REVOCATION.—In ac-
11 cordance with this paragraph, the Attorney
12 General, in consultation with the Secretary,
13 may revoke in whole or in part a certificate of
14 review issued under this section based on one or
15 more of the following grounds:

16 (i) After the expiration of the 2-year
17 period beginning on the date a person's
18 certificate is issued, the activities of the
19 person have not substantially accomplished
20 the purposes for the issuance of the certifi-
21 cate.

22 (ii) The person has failed to comply
23 with any of the terms or conditions im-
24 posed under the certificate by the Attorney

1 General or the Secretary under subsection
2 (b)(4).

3 (iii) The activities covered under the
4 certificate no longer satisfy the criteria set
5 forth in section 522(f).

6 (B) REQUEST FOR COMPLIANCE INFORMA-
7 TION.—If the Attorney General or the Sec-
8 retary has reason to believe that any of the
9 grounds for revocation of a certificate of review
10 described in subparagraph (A) may apply to a
11 person holding the certificate, the Attorney
12 General shall request such information from
13 such person as the Attorney General or the Sec-
14 retary deems necessary to resolve the matter of
15 compliance. Failure to comply with such request
16 shall be grounds for revocation of the certificate
17 under this paragraph.

18 (C) PROCEDURES FOR REVOCATION.—If
19 the Attorney General or the Secretary deter-
20 mines that any of the grounds for revocation of
21 a certificate of review described in subpara-
22 graph (A) apply to a person holding the certifi-
23 cate, or that such person has failed to comply
24 with a request made under subparagraph (B),
25 the Attorney General shall give written notice of

1 the determination to such person. The notice
2 shall include a statement of the circumstances
3 underlying, and the reasons in support of, the
4 determination. In the 60-day period beginning
5 30 days after the notice is given, the Attorney
6 General shall revoke the certificate or modify it
7 as the Attorney General or the Secretary deems
8 necessary to cause the certificate to apply only
9 to activities that meet the criteria set forth in
10 section 522(f).

11 (D) INVESTIGATION AUTHORITY.—For
12 purposes of carrying out this paragraph, the
13 Attorney General may conduct investigations in
14 the same manner as the Attorney General con-
15 ducts investigations under section 3 of the Anti-
16 trust Civil Process Act, except that no civil in-
17 vestigative demand may be issued to a person
18 to whom a certificate of review is issued if such
19 person is the target of such investigation.

20 (d) REVIEW OF DETERMINATIONS.—

21 (1) AVAILABILITY OF REVIEW FOR CERTAIN AC-
22 TIONS.—If the Attorney General denies, in whole or
23 in part, an application for a certificate of review or
24 for an amendment to a certificate, or revokes or
25 modifies a certificate pursuant to paragraph (3), the

1 applicant or certificate holder (as the case may be)
2 may, within 30 days of the denial or revocation,
3 bring an action in the United States District Court
4 for the District of Columbia to set aside the deter-
5 mination on the ground that such determination is
6 clearly erroneous.

7 (2) NO OTHER REVIEW PERMITTED.—Except
8 as provided in paragraph (1), no action by the At-
9 torney General, the Chair, or the Secretary pursuant
10 to this subtitle shall be subject to judicial review.

11 (3) EFFECT OF REJECTED APPLICATION.—If
12 the Attorney General denies, in whole or in part, an
13 application for a certificate of review or for an
14 amendment to a certificate, or revokes or amends a
15 certificate, neither the negative determination nor
16 the statement of reasons therefore shall be admissi-
17 ble in evidence, in any administrative or judicial pro-
18 ceeding, concerning any claim under the antitrust
19 laws.

20 (e) PUBLICATION OF DECISIONS.—The Attorney
21 General shall publish a notice in the Federal Register on
22 a timely basis of each decision made with respect to an
23 application for a certificate of review under this section
24 or the amendment or revocation of such a certificate, in

1 a manner that protects the confidentiality of any propri-
2 etary information relating to the application.

3 (f) ANNUAL REPORTS.—Every person to whom a cer-
4 tificate of review is issued shall submit to the Attorney
5 General an annual report, in such form and at such time
6 as the Attorney General may require, that contains any
7 necessary updates to the information required under sub-
8 section (b) and a description of the activities of the holder
9 under the certificate during the preceding year.

10 (g) RESTRICTIONS ON DISCLOSURE OF INFORMA-
11 TION.—

12 (1) WAIVER OF DISCLOSURE REQUIREMENTS
13 UNDER ADMINISTRATIVE PROCEDURE ACT.—Infor-
14 mation submitted by any person in connection with
15 the issuance, amendment, or revocation of a certifi-
16 cate of review shall be exempt from disclosure under
17 section 552 of title 5, United States Code.

18 (2) RESTRICTIONS ON DISCLOSURE OF COM-
19 MERCIAL OR FINANCIAL INFORMATION.—

20 (A) IN GENERAL.—Except as provided in
21 subparagraph (B), no officer or employee of the
22 United States shall disclose commercial or fi-
23 nancial information submitted in connection
24 with the issuance, amendment, or revocation of
25 a certificate of review if the information is priv-

1 ileged or confidential or if disclosure of the in-
2 formation would cause harm to the person who
3 submitted the information.

4 (B) EXCEPTIONS.—Subparagraph (A)
5 shall not apply with respect to information dis-
6 closed—

7 (i) upon a request made by the Con-
8 gress or any committee of the Congress,

9 (ii) in a judicial or administrative pro-
10 ceeding, subject to appropriate protective
11 orders,

12 (iii) with the consent of the person
13 who submitted the information,

14 (iv) in the course of making a deter-
15 mination with respect to the issuance,
16 amendment, or revocation of a certificate
17 of review, if the Attorney General deems
18 disclosure of the information to be nec-
19 essary in connection with making the de-
20 termination,

21 (v) in accordance with any require-
22 ment imposed by a statute of the United
23 States, or

24 (vi) in accordance with any rule or
25 regulation promulgated under subsection

1 (i) permitting the disclosure of the infor-
2 mation to an agency of the United States
3 or of a State on the condition that the
4 agency will disclose the information only
5 under the circumstances specified in
6 clauses (i) through (v).

7 (3) PROHIBITION AGAINST USE OF INFORMA-
8 TION TO SUPPORT OR ANSWER CLAIMS UNDER ANTI-
9 TRUST LAWS.—Any information disclosed in an ap-
10 plication for a certificate of review under this section
11 shall only be admissible into evidence in a judicial or
12 administrative proceeding for the sole purpose of es-
13 tablishing whether a person is entitled to the protec-
14 tions provided by such a certificate.

15 **SEC. 524. NOTIFICATIONS PROVIDING REDUCTION IN CER-**
16 **TAIN PENALTIES UNDER ANTITRUST LAW**
17 **FOR HEALTH CARE JOINT VENTURES.**

18 (a) NOTIFICATIONS DESCRIBED.—

19 (1) SUBMISSION OF NOTIFICATION BY VEN-
20 TURE.—Any party to a health care joint venture,
21 acting on such venture's behalf, may, not later than
22 90 days after entering into a written agreement to
23 form such venture or not later than 90 days after
24 the date of the enactment of this Act, whichever is

1 later, file with the Attorney General a written notifi-
2 cation disclosing—

3 (A) the identities of the parties to such
4 venture,

5 (B) the nature and objectives of such ven-
6 ture, and

7 (C) such additional information as the At-
8 torney General may require by regulation.

9 (2) FILING FEE.—The Attorney General may
10 require a filing fee to be submitted with the notifica-
11 tion to cover the cost of publication and the cost of
12 administering this section, except that the amount of
13 such fee shall not exceed \$250.

14 (3) SUBMISSION OF ADDITIONAL INFORMA-
15 TION.—

16 (A) REQUEST OF ATTORNEY GENERAL.—
17 At any time after receiving a notification filed
18 under paragraph (1), the Attorney General may
19 require the submission of additional information
20 or documentary material relevant to the pro-
21 posed health care joint venture.

22 (B) PARTIES TO VENTURE.—Any party to
23 a health care joint venture may submit such ad-
24 ditional information on the venture's behalf as
25 may be appropriate to ensure that the venture

1 will receive the protections provided under sub-
2 section (b).

3 (C) REQUIRED SUBMISSION OF INFORMA-
4 TION ON CHANGES TO VENTURE.—A health
5 care joint venture for which a notification is in
6 effect under this section shall submit informa-
7 tion on any change in the membership of the
8 venture not later than 90 days after such
9 change occurs.

10 (4) PUBLICATION OF NOTIFICATION.—

11 (A) INFORMATION MADE PUBLICLY AVAIL-
12 ABLE.—Not later than 30 days after receiving
13 a notification with respect to a venture under
14 paragraph (1), the Attorney General shall pub-
15 lish in the Federal Register a notice with re-
16 spect to the venture that identifies the parties
17 to the venture and generally describes the pur-
18 pose and planned activity of the venture. Prior
19 to its publication, the contents of the notice
20 shall be made available to the parties to the
21 venture.

22 (B) RESTRICTION ON DISCLOSURE OF
23 OTHER INFORMATION.—All information and
24 documentary material submitted pursuant to
25 this section and all information obtained by the

1 Attorney General in the course of any investiga-
2 tion or case with respect to a potential violation
3 of the antitrust laws by the health care joint
4 venture (other than information and material
5 described in subparagraph (A)) shall be exempt
6 from disclosure under section 552 of title 5,
7 United States Code, and shall not be made pub-
8 licly available by any agency of the United
9 States to which such section applies except in
10 a judicial proceeding in which such information
11 and material is subject to any protective order.

12 (5) WITHDRAWAL OF NOTIFICATION.—Any per-
13 son who files a notification pursuant to this section
14 may withdraw such notification before a publication
15 by the Attorney General pursuant to paragraph (4).

16 (6) NO JUDICIAL REVIEW PERMITTED.—Any
17 action taken or not taken by the Attorney General
18 with respect to notifications filed pursuant to this
19 subsection shall not be subject to judicial review.

20 (b) PROTECTIONS FOR VENTURES SUBJECT TO NO-
21 TIFICATION.—

22 (1) IN GENERAL.—

23 (A) PROTECTIONS DESCRIBED.—Except as
24 provided in subsection (c), the provisions of
25 paragraphs (2), (3), (4), and (5) shall apply

1 with respect to any action under the antitrust
2 laws challenging conduct within the scope of a
3 notification which is in effect pursuant to sub-
4 section (a)(1).

5 (B) TIMING OF PROTECTIONS.—The pro-
6 tections described in this subsection shall apply
7 to the venture that is the subject of a notifica-
8 tion under subsection (a)(1) as of the earlier
9 of—

10 (i) the date of the publication in the
11 Federal Register of the notice published
12 with respect to the notification; or

13 (ii) if such notice is not published dur-
14 ing the period required under subsection
15 (a)(4), the expiration of the 30-day period
16 that begins on the date the Attorney Gen-
17 eral receives any necessary information re-
18 quired to be submitted under subsection
19 (a)(1) or any additional information re-
20 quired by the Attorney General under sub-
21 section (a)(3)(A).

22 (2) APPLICABILITY OF RULE OF REASON
23 STANDARD.—In any action under the antitrust laws,
24 the conduct of any person which is within the scope
25 of a notification filed under subsection (a) shall not

1 be deemed illegal per se, but shall be judged on the
2 basis of its reasonableness, taking into account all
3 relevant factors affecting competition, including, but
4 not limited to, effects on competition in relevant
5 markets.

6 (3) LIMITATION ON RECOVERY TO ACTUAL
7 DAMAGES AND INTEREST.—Notwithstanding section
8 4 of the Clayton Act, any person who is entitled to
9 recovery under the antitrust laws for conduct that is
10 within the scope of a notification filed under sub-
11 section (a) shall recover the actual damages sus-
12 tained by such person and interest calculated at the
13 rate specified in section 1961 of title 28, United
14 States Code, for the period beginning on the earliest
15 date for which injury can be established and ending
16 on the date of judgment, unless the court finds that
17 the award of all or part of such interest is unjust
18 under the circumstances.

19 (4) AWARD OF ATTORNEY'S FEES AND COSTS
20 OF SUIT.—

21 (A) IN GENERAL.—In any action under the
22 antitrust laws brought against a health care
23 joint venture for conduct that is within the
24 scope of a notification filed under subsection

1 (a), the court shall, at the conclusion of the ac-
2 tion—

3 (i) award to a substantially prevailing
4 claimant the cost of suit attributable to
5 such claim, including a reasonable attor-
6 ney's fee, or

7 (ii) award to a substantially prevailing
8 party defending against such claim the
9 cost of such suit attributable to such claim,
10 including reasonable attorney's fee, if the
11 claim, or the claimant's conduct during
12 litigation of the claim, was frivolous, un-
13 reasonable, without foundation, or in bad
14 faith.

15 (B) OFFSET IN CASES OF BAD FAITH.—

16 The court may reduce an award made pursuant
17 to subparagraph (A) in whole or in part by an
18 award in favor of another party for any part of
19 the cost of suit (including a reasonable attor-
20 ney's fee) attributable to conduct during the
21 litigation by any prevailing party that the court
22 finds to be frivolous, unreasonable, without
23 foundation, or in bad faith.

24 (5) RESTRICTIONS ON ADMISSIBILITY OF IN-
25 FORMATION.—

1 (A) IN GENERAL.—Any information dis-
2 closed in a notification submitted under sub-
3 section (a)(1) and the fact of the publication of
4 a notification by the Attorney General under
5 subsection (a)(4) shall only be admissible into
6 evidence in a judicial or administrative proceed-
7 ing for the sole purpose of establishing whether
8 a party to a health care joint venture is entitled
9 to the protections described in this subsection.

10 (B) ACTIONS OF ATTORNEY GENERAL.—
11 No action taken by the Attorney General pursu-
12 ant to this section shall be admissible into evi-
13 dence in any judicial or administrative proceed-
14 ing for the purpose of supporting or answering
15 any claim under the antitrust laws.

16 (c) EXCEPTION FOR CERTAIN ACTIVITIES.—In the
17 event the parties cannot show procompetitive aspects nec-
18 essary to the success of the joint venture, the protections
19 described in subsection (b) should not be construed to
20 apply to conduct which constitutes per se price-fixing, bid-
21 rigging, or market allocation.

22 **SEC. 525. REVIEW AND REPORTS ON SAFE HARBORS, CER-**
23 **TIFICATES OF REVIEW, AND NOTIFICATIONS.**

24 (a) IN GENERAL.—The Attorney General, in con-
25 sultation with the Secretary and the Chair, shall periodi-

1 cally review the safe harbors designated under section 522,
2 the certificates of review issued under section 523, and
3 notification received under section 524, and—

4 (1) with respect to the safe harbors, issue modi-
5 fications to such safe harbors in such manner as the
6 Attorney General considers appropriate in accord-
7 ance with the requirements of section 522(f), which
8 modifications shall take effect 90 days after issu-
9 ance, unless disapproved by the Congress; and

10 (2) with respect to the certificates of review and
11 notifications, submit a report to Congress on the is-
12 suance of such certificates and receipt of notifica-
13 tions, including a description of the effect of such
14 certificates and notifications on increasing access to
15 high quality health care services at reduced costs.

16 (b) RECOMMENDATIONS FOR LEGISLATION.—The
17 Attorney General shall include in the reports submitted
18 under subsection (a)(2) any recommendations of the At-
19 torney General for legislation to improve the programs for
20 the issuance of certificates of review and receipt of notifi-
21 cations established under this subtitle.

22 **SEC. 526. RULES, REGULATIONS, AND GUIDELINES.**

23 (a) SAFE HARBORS, CERTIFICATES, AND NOTIFICA-
24 TIONS.—The Attorney General, in consultation with the
25 Secretary and the Chair, shall promulgate such rules, reg-

1 ulations, and guidelines as are necessary to carry out sec-
2 tions 522, 523, and 524.

3 (b) GUIDANCE FOR PROVIDERS.—

4 (1) IN GENERAL.—To promote greater cer-
5 tainty regarding the application of the antitrust laws
6 to activities in the health care market, the Attorney
7 General, in consultation with the Secretary and the
8 Chair, shall (not later than 1 year after the date of
9 the enactment of this Act), taking into account the
10 criteria used to designate safe harbors under section
11 522 and to grant certificates of review under section
12 523, publish guidelines—

13 (A) to define or provide assistance in de-
14 termining relevant geographic and product mar-
15 kets for health care services and providers of
16 health care services;

17 (B) to further collaborative activities which
18 may be helpful to enhance services in under-
19 served and geographically disadvantaged areas
20 such as rural markets and inner cities;

21 (C) to assist collaboration between provid-
22 ers (such as hospital networks, physician-hos-
23 pital organizations, and other groups of provid-
24 ers) which will help provide health care services
25 more efficiently;

1 (D) to further activities by which public
2 health clinics (including community health cen-
3 ters and migrant health centers under title III
4 of the Public Health Service Act) may partici-
5 pate in networks and other collaborative activi-
6 ties in order to enhance services in underserved
7 areas;

8 (E) to assist providers of health care serv-
9 ices in analyzing whether the activities of such
10 providers may be subject to a safe harbor under
11 section 522;

12 (F) to provide clarification for activities in
13 the general subject matter areas described in
14 the safe harbors in section 522, but which fall
15 outside the safe harbors; and

16 (G) to describe specific types of activities
17 which would meet the requirements for issuance
18 of a certificate of review under section 523, and
19 summarizing the factual and legal bases on
20 which the activities would meet the require-
21 ments.

22 (2) PERIODIC UPDATE.—The Attorney General
23 shall periodically update the guidelines published
24 under paragraph (1) as the Attorney General consid-
25 ers appropriate.

1 (3) WAIVER OF ADMINISTRATIVE PROCEDURE
2 ACT.—Section 553 of title 5, United States Code,
3 shall not apply to the issuance of guidelines under
4 paragraph (1).

5 **SEC. 527. DEFINITIONS.**

6 In this subtitle, the following definitions shall apply:

7 (1) The term “antitrust laws”—

8 (A) has the meaning given it in subsection
9 (a) of the first section of the Clayton Act (15
10 U.S.C. 12(a)), except that such term includes
11 section 5 of the Federal Trade Commission Act
12 (15 U.S.C. 45) to the extent such section ap-
13 plies to unfair methods of competition; and

14 (B) includes any State law similar to the
15 laws referred to in subparagraph (A).

16 (2) The term “Chair” means the Chair of the
17 Federal Trade Commission.

18 (3) The term “health benefit plan” means any
19 hospital or medical expense incurred policy or certifi-
20 cate, hospital or medical service plan contract, or
21 health maintenance subscriber contract, or a mul-
22 tiple employer welfare arrangement or employee ben-
23 efit plan (as defined under the Employee Retirement
24 Income Security Act of 1974) which provides bene-
25 fits with respect to health care services.

1 (4) The term “health care joint venture” means
2 a joint venture of 2 or more persons formed for the
3 purpose of providing health care services, including
4 attempts to enter into or perform a contract or
5 agreement to provide such services.

6 (5) The term “health care services” means any
7 services for which payment may be made under a
8 health benefit plan, including services related to the
9 delivery or administration of such services.

10 (6) The term “medical self-regulatory entity”
11 means a medical society or association, a specialty
12 board, a recognized accrediting agency, or a hospital
13 medical staff, and includes the members, officers,
14 employees, consultants, and volunteers or commit-
15 tees of such an entity.

16 (7) The term “person” includes a State or unit
17 of local government.

18 (8) The term “provider of health care services”
19 means any individual or entity that is engaged in the
20 delivery of health care services in a State and that
21 is required by State law or regulation to be licensed
22 or certified by the State to engage in the delivery of
23 such services in the State.

24 (9) The term “Secretary” means the Secretary
25 of Health and Human Services.

1 (10) The term “specialty group” means a medi-
2 cal specialty or subspecialty in which a provider of
3 health care services may be licensed to practice by
4 a State (as determined by the Secretary in consulta-
5 tion with the certification boards for such specialties
6 and subspecialties).

7 (11) The term “standard setting and enforce-
8 ment activities” means—

9 (A) accreditation of health care practition-
10 ers, health care providers, medical education in-
11 stitutions, or medical education programs,

12 (B) technology assessment and risk man-
13 agement activities,

14 (C) the development and implementation of
15 practice guidelines or practice parameters, or

16 (D) official peer review proceedings under-
17 taken by a hospital medical staff (or committee
18 thereof) or a medical society or association for
19 purposes of evaluating the professional conduct
20 or quality of health care provided by a medical
21 professional.

22 **TITLE VI—ADMINISTRATIVE** 23 **SIMPLIFICATION AND PRIVACY**

24 **SEC. 601. ADMINISTRATIVE SIMPLIFICATION.**

25 (a) HEALTH INFORMATION NETWORK.—

1 (1) IN GENERAL.—Title XI of the Social Secu-
 2 rity Act (42 U.S.C. 1301 et seq.) is amended by
 3 adding at the end the following new subtitle:

4 **“Subtitle B—Administrative**
 5 **Simplification**

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“Sec. 11731. Accessing health information for authorized purposes.

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“PART IX—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL
INFORMATION SYSTEMS

- “Sec. 11781. Grants for demonstration projects.

1 **“PART I—PURPOSE AND DEFINITIONS**

2 **“SEC. 11701. PURPOSE.**

3 “‘It is the purpose of this subtitle to improve the effi-
4 ciency and effectiveness of the health care system, includ-
5 ing the medicare program under title XVIII and the med-
6 icaid program under title XIX, by encouraging the devel-
7 opment of a health information network through the es-
8 tablishment of standards and requirements for the elec-
9 tronic transmission of certain health information.

10 **“SEC. 11702. DEFINITIONS.**

11 “‘For purposes of this subtitle:

12 “(1) CODE SET.—The term ‘code set’ means
13 any set of codes used for encoding data elements,
14 such as tables of terms, medical concepts, medical
15 diagnostic codes, or medical procedure codes.

16 “(2) COORDINATION OF BENEFITS.—The term
17 ‘coordination of benefits’ means determining and co-
18 ordinating the financial obligations of health plans

1 when health care benefits are payable under 2 or
2 more health plans.

3 “(3) HEALTH CARE PROVIDER.—The term
4 ‘health care provider’ includes a provider of services
5 (as defined in section 1861(u)), a provider of medi-
6 cal or other health services (as defined in section
7 1861(s)), and any other person furnishing health
8 care services or supplies.

9 “(4) HEALTH INFORMATION.—The term ‘health
10 information’ means any information, whether oral or
11 recorded in any form or medium that—

12 “(A) is created or received by a health care
13 provider, health plan, health oversight agency
14 (as defined in section 11802), health re-
15 searcher, public health authority (as defined in
16 section 11802), employer, life insurer, school or
17 university, or health information network serv-
18 ice certified under section 11741; and

19 “(B) relates to the past, present, or future
20 physical or mental health or condition of an in-
21 dividual, the provision of health care to an indi-
22 vidual, or the past, present, or future payment
23 for the provision of health care to an individual.

24 “(5) HEALTH INFORMATION NETWORK.—The
25 term ‘health information network’ means the health

1 information system that is formed through the appli-
2 cation of the requirements and standards established
3 under this subtitle.

4 “(6) HEALTH INFORMATION PROTECTION OR-
5 GANIZATION.—The term ‘health information protec-
6 tion organization’ means a private entity or an en-
7 tity operated by a State that accesses standard data
8 elements of health information through the health
9 information network, processes such information
10 into non-identifiable health information, and may
11 store such information.

12 “(7) HEALTH INFORMATION NETWORK SERV-
13 ICE.—The term ‘health information network serv-
14 ice’—

15 “(A) means a private entity or an entity
16 operated by a State that enters into contracts
17 to—

18 “(i) process or facilitate the process-
19 ing of nonstandard data elements of health
20 information into standard data elements;

21 “(ii) provide the means by which per-
22 sons are connected to the health informa-
23 tion network for purposes of meeting the
24 requirements of this subtitle, including the

1 holding of standard data elements of
2 health information;

3 “(iii) provide authorized access to
4 health information through the health in-
5 formation network; or

6 “(iv) provide specific information
7 processing services, such as automated co-
8 ordination of benefits and claims trans-
9 action routing; and

10 “(B) includes a health information protec-
11 tion organization.

12 “(8) HEALTH PLAN.—The term ‘health plan’
13 has the meaning given such term in section
14 21003(a)(1) except that such term shall include sub-
15 paragraphs (C), (D), (E), (F), and (H) of such sec-
16 tion.

17 “(9) NON-IDENTIFIABLE HEALTH INFORMA-
18 TION.—The term ‘non-identifiable health informa-
19 tion’ means health information that is not protected
20 health information as defined in section 11802.

21 “(10) HEALTH RESEARCHER.—The term
22 ‘health researcher’ shall have the meaning given
23 such term under section 11802.

24 “(11) PATIENT MEDICAL RECORD INFORMA-
25 TION.—The term ‘patient medical record informa-

1 tion’ means health information derived from a clinical
2 cal encounter that relates to the physical or mental
3 condition of an individual.

4 “(12) STANDARD.—The term ‘standard’ when
5 referring to an information transaction or to data
6 elements of health information means the trans-
7 action or data elements meet any standard adopted
8 by the Secretary under part II that applies to such
9 information transaction or data elements.

10 **“PART II—STANDARDS FOR DATA ELEMENTS**
11 **AND INFORMATION TRANSACTIONS**

12 **“SEC. 11711. GENERAL REQUIREMENTS ON SECRETARY.**

13 “(a) IN GENERAL.—The Secretary shall adopt stand-
14 ards and modifications to standards under this subtitle
15 that are—

16 “(1) consistent with the objective of reducing
17 the costs of providing and paying for health care;
18 and

19 “(2) in use and generally accepted or developed
20 or modified by the standards setting organizations
21 accredited by the American National Standard Insti-
22 tute (ANSI).

23 “(b) INITIAL STANDARDS.—The Secretary may de-
24 velop an expedited process for the adoption of initial
25 standards under this subtitle.

1 “(c) PAPER FORMATS.—The Secretary may develop
2 methods by which a person may use the standards adopted
3 by the Secretary under this subtitle with respect to health
4 information that is in written rather than electronic form.

5 **“SEC. 11712. STANDARDS FOR DATA ELEMENTS OF HEALTH**
6 **INFORMATION.**

7 “(a) IN GENERAL.—The Secretary shall adopt stand-
8 ards necessary to make data elements of the following
9 health information uniform and compatible for electronic
10 transmission through the health information network:

11 “(1) the health information that is appropriate
12 for transmission in connection with transactions de-
13 scribed in subsections (a) and (b) of section 11721;

14 “(2) any quality information required to be sub-
15 mitted by a health plan to a State under title XXI;
16 and

17 “(3) patient medical record information.

18 “(b) ADDITIONS.—The Secretary may make addi-
19 tions to the sets of data elements adopted under sub-
20 section (a) as the Secretary determines appropriate in a
21 manner that minimizes the disruption and cost of compli-
22 ance with such additions.

23 “(c) CERTAIN DATA ELEMENTS.—

24 “(1) UNIQUE HEALTH IDENTIFIERS.—The Sec-
25 retary shall adopt standards for a standard unique

1 health identifier for each individual, employer, health
2 plan, and health care provider for use in the health
3 care system.

4 “(2) CODE SETS.—

5 “(A) IN GENERAL.—The Secretary, in con-
6 sultation with experts from the private sector
7 and Federal agencies, shall—

8 “(i) select code sets for appropriate
9 data elements from among the code sets
10 that have been developed by private and
11 public entities; or

12 “(ii) establish code sets for such data
13 elements if no code sets for the data ele-
14 ments have been developed.

15 “(B) DISTRIBUTION.—The Secretary shall
16 establish efficient and low-cost procedures for
17 distribution of code sets and modifications to
18 such code sets under section 11714(c).

19 **“SEC. 11713. INFORMATION TRANSACTION STANDARDS.**

20 “(a) IN GENERAL.—The Secretary shall adopt tech-
21 nical standards relating to the method by which data ele-
22 ments of health information that have been standardized
23 under section 11712 may be transmitted electronically, in-
24 cluding standards with respect to the format in which such
25 data elements shall be transmitted.

1 “(b) SPECIAL RULE FOR COORDINATION OF BENE-
2 FITS.—Any standards adopted by the Secretary under
3 paragraph (1) that relate to coordination of benefits shall
4 provide that a claim for reimbursement for medical serv-
5 ices furnished is tested by an algorithm specified by the
6 Secretary against all records of enrollment and eligibility
7 for the individual who received such services to determine
8 any primary and secondary obligors for payment.

9 “(c) ELECTRONIC SIGNATURE.—The Secretary, in
10 coordination with the Secretary of Commerce, shall pro-
11 mulgate regulations specifying procedures for the elec-
12 tronic transmission and authentication of signatures, com-
13 pliance with which will be deemed to satisfy State and
14 Federal statutory requirements for written signatures with
15 respect to information transactions required by this Act
16 and written signatures on medical records and prescrip-
17 tions.

18 **“SEC. 11714. TIMETABLES FOR ADOPTION OF STANDARDS.**

19 “(a) INITIAL STANDARDS FOR DATA ELEMENTS.—
20 The Secretary shall adopt standards relating to—

21 “(1) the data elements for the information de-
22 scribed in section 11712(a)(1) not later than 9
23 months after the date of the enactment of this sub-
24 title (except in the case of standards with respect to
25 data elements for claims attachments which shall be

1 adopted not later than 24 months after the date of
2 the enactment of this subtitle);

3 “(2) the data elements for the information de-
4 scribed in section 11712(a)(2) not later than 9
5 months after the date of the enactment of this sub-
6 title;

7 “(3) data elements for patient medical record
8 information not earlier than 5 years and not later
9 than 10 years after the date of the enactment of this
10 subtitle; and

11 “(4) any addition to a set of data elements, in
12 conjunction with making such an addition.

13 “(b) INITIAL STANDARDS FOR INFORMATION TRANS-
14 ACTIONS.—The Secretary shall adopt standards relating
15 to information transactions under section 11713 not later
16 than 9 months after the date of the enactment of this sub-
17 title (except in the case of standards for claims attach-
18 ments which shall be adopted not later than 24 months
19 after the date of the enactment of this subtitle).

20 “(c) MODIFICATIONS TO STANDARDS.—

21 “(1) IN GENERAL.—Except as provided in para-
22 graph (2), the Secretary shall review the standards
23 adopted under this subtitle and shall adopt modified
24 standards as determined appropriate, but no more
25 frequently than once every 6 months. Any modifica-

tion to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

“(2) SPECIAL RULES.—

“(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

“(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

“(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets to accommodate changes in biomedical science and health care delivery.

“(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the

1 modified code set shall include instructions
2 on how data elements that were encoded
3 prior to the modification are to be con-
4 verted or translated so as to preserve the
5 value of the data elements. Any modifica-
6 tion to a code set under this subsection
7 shall be implemented in a manner that
8 minimizes the disruption and cost of com-
9 plying with such modification.

10 “(d) EVALUATION OF STANDARDS.—The Secretary
11 may establish a process to measure or verify the consist-
12 ency of standards adopted or modified under this subtitle.
13 Such process may include demonstration projects and
14 analysis of the cost of implementing such standards and
15 modifications.

16 **“PART III—REQUIREMENTS WITH RESPECT TO**
17 **CERTAIN TRANSACTIONS AND INFORMATION**

18 **“SEC. 11721. REQUIREMENTS WITH RESPECT TO CERTAIN**
19 **TRANSACTIONS AND INFORMATION.**

20 “(a) REQUIREMENTS ON PLANS AND PROVIDERS RE-
21 LATING TO FINANCIAL AND ADMINISTRATIVE TRANS-
22 ACTIONS.—If a health care provider or a health plan con-
23 ducts any of the following transactions, such transactions
24 shall be standard transactions and the information trans-

mitted or received in connection with such transaction
shall be in the form of standard data elements:

“(1) Claims (including coordination of benefits).

“(2) Claims attachments.

“(3) Responses to research inquiries by a health
researcher.

“(3) Other transactions determined appropriate
by the Secretary consistent with the goal of reducing
administrative costs.

“(b) REQUIREMENT ONLY ON PLANS RELATING TO
FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a
person desires to conduct any of the following transactions
with a health plan as a standard transaction, the health
plan shall conduct such standard transaction and the in-
formation transmitted or received in connection with such
transaction shall be in the form of standard data elements:

“(1) Enrollment and disenrollment.

“(2) Eligibility.

“(3) Payment and remittance advice.

“(4) Premium payments.

“(5) First report of injury.

“(6) Claims status.

“(7) Referral certification and authorization.

1 “(8) Other transactions determined appropriate
2 by the Secretary consistent with the goal of reducing
3 administrative costs.

4 “(c) REQUIREMENT ON PLANS RELATING TO QUAL-
5 ITY INFORMATION.—Any quality information required to
6 be submitted by a health plan to a State under title XXI
7 shall be in the form of standard data elements and the
8 transmission of such data shall be in the form of a stand-
9 ard transaction.

10 “(d) REQUIREMENT WITH RESPECT TO DISCLOSURE
11 OF INFORMATION.—

12 “(1) IN GENERAL.—A health plan or health
13 care provider shall make the standard data elements
14 transmitted or received by such plan or provider in
15 connection with the transactions described in sub-
16 sections (a), (b), and (c) or acquired under section
17 11764(a) available for disclosure as authorized by
18 this subtitle.

19 “(2) SPECIAL RULE.—In the case of a health
20 care provider that does not file claims, such provider
21 shall be responsible for making standard data ele-
22 ments for encounter information available for disclo-
23 sure as authorized by this subtitle.

24 “(e) SATISFACTION OF REQUIREMENTS.—A health
25 care provider or health plan may satisfy the requirement

1 imposed on such provider or plan under subsection (a),
2 (b), (c), or (d) by—

3 “(1) directly transmitting standard data ele-
4 ments;

5 “(2) submitting nonstandard data elements to a
6 health information network service certified under
7 section 11741 for processing into standard data ele-
8 ments and transmission; or

9 “(3) in the case of a provider, submitting data
10 elements to a plan which satisfies the requirements
11 imposed on such provider on the provider’s behalf.

12 “(f) TIMELINESS.—A health care provider or health
13 plan shall be determined to have satisfied a requirement
14 imposed under this section only if the action required is
15 completed in a timely manner, as determined by the Sec-
16 retary. In setting standards for timeliness, the Secretary
17 shall take into consideration the age and the amount of
18 information being requested.

19 **“SEC. 11722. TIMETABLES FOR COMPLIANCE WITH RE-**
20 **QUIREMENTS.**

21 “(a) INITIAL COMPLIANCE.—

22 “(1) IN GENERAL.—Not later than 12 months
23 after the date on which standards are adopted under
24 part II with respect to a type of transaction or data
25 elements for a type of health information, a health

1 plan or health care provider shall comply with the
2 requirements of this subtitle with respect to such
3 transaction or information.

4 “(2) ADDITIONAL DATA ELEMENTS.—Not later
5 than 12 months after the date on which the Sec-
6 retary adopts an addition to a set of data elements
7 for health information under part II, a health plan
8 or health care provider shall comply with the re-
9 quirements of this subtitle using such data elements.

10 “(b) COMPLIANCE WITH MODIFIED STANDARDS.—

11 “(1) IN GENERAL.—If the Secretary adopts a
12 modified standard under part II, a health plan or
13 health care provider shall be required to comply with
14 the modified standard at such time as the Secretary
15 determines appropriate taking into account the time
16 needed to comply due to the nature and extent of
17 the modification.

18 “(2) SPECIAL RULE.—In the case of modifica-
19 tions to standards that do not occur within the 12-
20 month period beginning on the date such standards
21 are adopted, the time determined appropriate by the
22 Secretary under paragraph (1) shall be no sooner
23 than the last day of the 90-day period beginning on
24 the date such modified standard is adopted and no

1 later than the last day of the 12 month period begin-
2 ning on the date such modified standard is adopted.

3 **“PART IV—ACCESSING HEALTH INFORMATION**

4 **“SEC. 11731. ACCESSING HEALTH INFORMATION FOR AU-**
5 **THORIZED PURPOSES.**

6 “(a) IN GENERAL.—The Secretary shall adopt tech-
7 nical standards for appropriate persons, including health
8 plans, health care providers, health information network
9 services certified under section 11741, health researchers,
10 and Federal and State agencies, to locate and access the
11 health information that is available through the health in-
12 formation network due to the requirements of this subtitle.
13 Such technical standards shall ensure that any request to
14 locate or access information shall be authorized under sub-
15 title C.

16 “(b) PROCUREMENT RULE FOR GOVERNMENT AGEN-
17 CIES.—

18 “(1) IN GENERAL.—Health information protec-
19 tion organizations certified under section 11741
20 shall make available to a Federal or State agency
21 pursuant to a Federal Acquisition Regulation (or an
22 equivalent State system), any non-identifiable health
23 information that is requested by such agency.

24 “(2) CERTAIN INFORMATION AVAILABLE AT
25 LOW COST.—If a health information protection orga-

1 nization described in paragraph (1) needs informa-
2 tion from a health plan or health care provider in
3 order to comply with a request of a Federal or State
4 agency that is necessary to comply with a require-
5 ment under this Act, such plan or provider shall
6 make such information available to such organiza-
7 tion for a charge that does not exceed the reasonable
8 cost of transmitting the information. If requested, a
9 health information protection organization that re-
10 ceives information under the preceding sentence
11 must make such information available to any other
12 such organization that is certified under section
13 11741 for a charge that does not exceed the reason-
14 able cost of transmitting the information.

15 “(c) FUNCTIONAL SEPARATION.—The standards
16 adopted by the Secretary under subsection (a) shall ensure
17 that any health information disclosed under such sub-
18 section shall not, after such disclosure, be used or released
19 for an administrative, regulatory, or law enforcement pur-
20 pose unless such disclosure was made for such purpose.

21 “(d) PUBLIC USE FUNCTIONS.—Nothing in this sub-
22 title shall be construed to limit the authority of a Federal
23 or State agency to make non-identifiable health informa-
24 tion available for public use functions.

1 **“SEC. 11732. RESPONDING TO ACCESS REQUESTS.**

2 “(a) IN GENERAL.—The Secretary may adopt, and
3 modify as appropriate, standards under which a health
4 care provider or health plan shall respond to requests for
5 access to health information consistent with this subtitle
6 and subtitle C.

7 “(b) STANDARDS DESCRIBED.—The standards under
8 subsection (a) shall provide—

9 “(1) for a standard format under which a pro-
10 vider or plan will respond to each request either by
11 satisfying the request or responding with an expla-
12 nation of the specific restriction which results in a
13 failure to satisfy the request; and

14 “(2) that any restrictions will not prevent a
15 plan or provider from responding to a request in a
16 timely manner taking into account the age and
17 amount of the information being requested.

18 “(c) CONSTRUCTION.—Nothing in this section shall
19 be construed as permitting a health care provider or health
20 plan to refuse to disclose any health information that is
21 required to be disclosed by law.

22 **“SEC. 11733. LENGTH OF TIME INFORMATION SHOULD BE**
23 **ACCESSIBLE.**

24 “The Secretary shall adopt standards with respect to
25 the length of time any standard data elements for a type

1 of health information should be accessible through the
2 health information network.

3 **“SEC. 11734. TIMETABLES FOR ADOPTION OF STANDARDS**
4 **AND COMPLIANCE.**

5 “(a) INITIAL STANDARDS.—The Secretary shall
6 adopt standards under this part not later than 9 months
7 after the date of the enactment of this subtitle and such
8 standards shall be effective upon adoption.

9 “(b) MODIFICATIONS TO STANDARDS.—

10 “(1) IN GENERAL.—Except as provided in para-
11 graph (2), the Secretary shall review the standards
12 adopted under this part and shall adopt modified
13 standards as determined appropriate, but no more
14 frequently than once every 6 months. Any modifica-
15 tion to standards shall be completed in a manner
16 which minimizes the disruption and cost of compli-
17 ance. Any modifications to standards adopted under
18 this part shall be effective upon adoption.

19 “(2) SPECIAL RULE.—The Secretary shall not
20 adopt modifications to any standards adopted under
21 this part during the 12-month period beginning on
22 the date such standards are adopted unless the Sec-
23 retary determines that a modification is necessary in
24 order to permit compliance with the requirements of
25 this part.

1 **“PART V—STANDARDS AND CERTIFICATION FOR**
2 **HEALTH INFORMATION NETWORK**

3 **“SEC. 11741. STANDARDS AND CERTIFICATION FOR HEALTH**
4 **INFORMATION NETWORK SERVICES.**

5 “(a) STANDARDS FOR OPERATION.—The Secretary
6 shall adopt standards with respect to the operation of
7 health information network services to ensure that—

8 “(1) such services cooperate with one another
9 to form the health information network;

10 “(2) such services meet all of the requirements
11 under subtitle C that are applicable to such services;

12 “(3) such services make public information con-
13 cerning their performance, as measured by uniform
14 indicators such as accessibility, transaction respon-
15 siveness, administrative efficiency, reliability, de-
16 pendability, and any other indicator determined ap-
17 propriate by the Secretary;

18 “(4) such services have security procedures that
19 are consistent with the privacy requirements under
20 subtitle C, including secure methods of access to and
21 transmission of data;

22 “(5) such services, if they are part of a larger
23 organization, have policies and procedures in place
24 which isolate their activities with respect to process-
25 ing information in a manner that prevents unauthor-

1 ized access to such information by such larger orga-
2 nization.

3 “(b) CERTIFICATION BY THE SECRETARY.—

4 “(1) ESTABLISHMENT.—Not later than 12
5 months after the date of the enactment of this sub-
6 title, the Secretary shall establish a certification pro-
7 cedure for health information network services which
8 ensures that certified services are qualified to meet
9 the requirements of this subtitle and the standards
10 established by the Secretary under this section. Such
11 certification procedure shall be implemented in a
12 manner that minimizes the costs and delays of oper-
13 ations for such services.

14 “(2) APPLICATION.—Each entity desiring to be
15 certified as a health information network service
16 shall apply to the Secretary for certification in a
17 form and manner determined appropriate by the
18 Secretary.

19 “(3) AUDITS AND REPORTS.—The procedure
20 established under paragraph (1) shall provide for au-
21 dits by the Secretary and reports by an entity cer-
22 tified under this section as the Secretary determines
23 appropriate in order to monitor such entity’s compli-
24 ance with the requirements of this subtitle, subtitle

1 C, and the standards established by the Secretary
2 under this section.

3 “(c) LOSS OF CERTIFICATION.—

4 “(1) MANDATORY TERMINATION.—Except as
5 provided in paragraph (3), if a health information
6 network service violates a requirement imposed on
7 such service under subtitle C, its certification under
8 this section shall be terminated unless the Secretary
9 determines that appropriate corrective action has
10 been taken.

11 “(2) DISCRETIONARY TERMINATION.—If a
12 health information network service violates a re-
13 quirement or standard imposed under this subtitle
14 and a penalty has been imposed under section
15 11751, the Secretary shall review the certification of
16 such service and may terminate such certification.

17 “(3) CONDITIONAL CERTIFICATION—The Sec-
18 retary may establish a procedure under which a
19 health information network service may remain cer-
20 tified on a conditional basis if the service is operat-
21 ing consistently with a plan intended to correct any
22 violations described in paragraphs (1) or (2). Such
23 procedure may provide for the appointment of a
24 trustee to continue operation of the service until the
25 requirements for full certification are met.

1 “(d) CERTIFICATION BY PRIVATE ENTITIES.—The
2 Secretary shall designate private entities to conduct the
3 certification procedures established by the Secretary under
4 this section. A health information network service certified
5 by such an entity in accordance with such designation
6 shall be considered to be certified by the Secretary.

7 **“SEC. 11742. ENSURING AVAILABILITY OF INFORMATION.**

8 “The Secretary shall establish a procedure under
9 which a health plan or health care provider which does
10 not have the ability to transmit standard data elements
11 directly or does not have access to a health information
12 network service certified under section 11741 shall be able
13 to make health information available for disclosure as au-
14 thorized by this subtitle.

15 **“PART VI—PENALTIES**

16 **“SEC. 11751. GENERAL PENALTY FOR FAILURE TO COMPLY**
17 **WITH REQUIREMENTS AND STANDARDS.**

18 “(a) IN GENERAL.—Except as provided in subsection
19 (b), the Secretary shall impose on any person that violates
20 a requirement or standard imposed under this subtitle a
21 penalty of not more than \$1,000 for each violation. The
22 provisions of section 1128A (other than subsections (a)
23 and (b) and the second sentence of subsection (f)) shall
24 apply to the imposition of a civil money penalty under this

1 subsection in the same manner as such provisions apply
2 to the imposition of a penalty under section 1128A.

3 “(b) LIMITATIONS.—

4 “(1) NONCOMPLIANCE NOT DISCOVERED EXER-
5 CISING REASONABLE DILIGENCE.—A penalty may
6 not be imposed under subsection (a) if it is estab-
7 lished to the satisfaction of the Secretary that the
8 person liable for the penalty did not know, and by
9 exercising reasonable diligence would not have
10 known, that such person failed to comply with the
11 requirement or standard described in subsection (a).

12 “(2) FAILURES DUE TO REASONABLE CAUSE.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraphs (B) and (C), a penalty may not
15 be imposed under subsection (a) if—

16 “(i) the failure to comply was due to
17 reasonable cause and not to willful neglect;
18 and

19 “(ii) the failure to comply is corrected
20 during the 30-day period beginning on the
21 1st date the person liable for the penalty
22 knew, or by exercising reasonable diligence
23 would have known, that the failure to com-
24 ply occurred.

25 “(B) EXTENSION OF PERIOD.—

1 “(i) NO PENALTY.—The period re-
2 ferred to in subparagraph (A)(ii) may be
3 extended as determined appropriate by the
4 Secretary based on the nature and extent
5 of the failure to comply.

6 “(ii) ASSISTANCE.—If the Secretary
7 determines that a health plan or health
8 care provider failed to comply because such
9 person was unable to comply, the Secretary
10 may provide technical assistance to such
11 person. Such assistance shall be provided
12 in any manner determined appropriate by
13 the Secretary.

14 “(3) REDUCTION.—In the case of a failure to
15 comply which is due to reasonable cause and not to
16 willful neglect, any penalty under subsection (a) that
17 is not entirely waived under paragraph (2) may be
18 waived to the extent that the payment of such pen-
19 alty would be excessive relative to the compliance
20 failure involved.

21 **“PART VII—MISCELLANEOUS PROVISIONS**

22 **“SEC. 11761. IMPOSITION OF ADDITIONAL REQUIREMENTS.**

23 “(a) DATA ELEMENT STANDARDS.—A person may
24 not impose a standard on another person that is in addi-

1 tion to the standards adopted by the Secretary under sec-
2 tion 11712 unless—

3 “(1) such person voluntarily agrees to such
4 standard; or

5 “(2) a waiver is granted under subsection (c) to
6 impose such standard.

7 “(b) TRANSACTIONS AND ACCESS STANDARDS.—A
8 person may not impose a standard on another person that
9 is in addition to the standards adopted by the Secretary
10 under section 11713 or 11731 unless such person volun-
11 tarily agrees to such standard.

12 “(c) CONDITIONS FOR WAIVERS.—

13 “(1) IN GENERAL.—A person may request a
14 waiver from the Secretary in order to require an-
15 other person to comply with a standard that is in
16 addition to the standards adopted by the Secretary
17 under section 11712.

18 “(2) CONSIDERATION OF WAIVER REQUESTS.—
19 No waiver may be granted unless the Secretary de-
20 termines that the value of the data to be exchanged
21 for research or other purposes significantly out-
22 weighs the administrative cost of the additional
23 standard taking into consideration the burden of the
24 timing of the imposition of the additional standard.

1 “(3) ANONYMOUS REPORTING.—If a person at-
2 tempts to impose a standard in addition to the
3 standards adopted by the Secretary under section
4 11712, the person on whom such additional stand-
5 ard is being imposed may contact the Secretary. The
6 Secretary shall develop a procedure under which the
7 contacting person shall remain anonymous. The Sec-
8 retary shall notify the person imposing the addi-
9 tional standard that the additional standard may not
10 be imposed unless the other person voluntarily
11 agrees to such standard or a waiver is obtained
12 under this subsection.

13 **“SEC. 11762. EFFECT ON STATE LAW.**

14 “(a) IN GENERAL.—A provision, requirement, or
15 standard under this subtitle shall supersede any contrary
16 provision of State law, including—

17 “(1) a provision of State law that requires med-
18 ical or health plan records (including billing informa-
19 tion) to be maintained or transmitted in written
20 rather than electronic form, and

21 “(2) a provision of State law which provides for
22 requirements or standards that are more stringent
23 than the requirements or standards under this sub-
24 title;

1 except where the Secretary determines that the provision
2 is necessary to prevent fraud and abuse, with respect to
3 controlled substances, or for other purposes.

4 “(b) PUBLIC HEALTH REPORTING.—Nothing in this
5 subtitle shall be construed to invalidate or limit the au-
6 thority, power, or procedures established under any law
7 providing for the reporting of disease or injury, child
8 abuse, birth, or death, public health surveillance, or public
9 health investigation or intervention.

10 **“SEC. 11764. HEALTH INFORMATION CONTINUITY.**

11 “(a) INFORMATION HELD BY HEALTH PLANS AND
12 PROVIDERS.—If a health plan or health care provider
13 takes any action that would threaten the continued avail-
14 ability of the standard data elements of health information
15 held by such plan or provider, such data elements shall
16 be obtained by the State in which such plan or provider
17 is located. The State shall ensure that such data elements
18 are transferred to a health plan or health care provider
19 in accordance with procedures established by the Sec-
20 retary.

21 “(b) INFORMATION HELD BY HEALTH INFORMATION
22 NETWORK SERVICES.—If a health information network
23 service certified under section 11741 loses its certified sta-
24 tus or takes any action that would threaten the continued
25 availability of the standard data elements of health infor-

1 mation held by such service, such data elements shall be
2 transferred to another health information network service
3 certified under section 11741, as designated by the Sec-
4 retary.

5 **“SEC. 11765. PROTECTION OF COMMERCIAL INFORMATION.**

6 “In adopting standards under this subtitle, the Sec-
7 retary shall not require disclosure of trade secrets and
8 confidential commercial information by entities operating
9 in the health information network except as required by
10 law.

11 **“SEC. 11766. PAYMENT FOR HEALTH CARE SERVICES OR**
12 **HEALTH PLAN PREMIUMS.**

13 “Nothing in this subtitle shall be construed to pro-
14 hibit payments for health care services or health plan pre-
15 miums from being made by debit, credit, or other payment
16 cards or numbers or other electronic payment means.

17 **“SEC. 11767. HEALTH SECURITY CARDS.**

18 “The Secretary shall adopt standards relating to the
19 form of any health security cards that a health plan may
20 issue and the information to be encoded electronically on
21 such cards.

22 **“SEC. 11768. AUTHORIZATION OF APPROPRIATIONS.**

23 “There are authorized to be appropriated such sums
24 as may be necessary to carry out the purposes of this sub-
25 title.

1 **“PART VIII—ASSISTANCE TO THE SECRETARY**

2 **“SEC. 11771. GENERAL REQUIREMENT ON SECRETARY.**

3 “In complying with any requirements imposed under
4 this subtitle, the Secretary shall rely on recommendations
5 of the Health Information Advisory Committee established
6 under section 11772 and shall consult with appropriate
7 Federal agencies.

8 **“SEC. 11772. HEALTH INFORMATION ADVISORY COMMIT-**
9 **TEE.**

10 “(a) ESTABLISHMENT.—There is established a com-
11 mittee to be known as the Health Care Information Advi-
12 sory Committee.

13 “(b) DUTY.—

14 “(1) IN GENERAL.—The committee shall—

15 “(A) provide assistance to the Secretary in
16 complying with the requirements imposed on
17 the Secretary under this subtitle and subtitle C;

18 “(B) be generally responsible for advising
19 the Secretary and the Congress on the status of
20 the health information network; and

21 “(C) make recommendations to correct any
22 problems that may occur in the network’s im-
23 plementation and ongoing operations and to re-
24 fine and improve the network.

25 “(2) TECHNICAL ASSISTANCE.—In performing
26 its duties under this subsection, the committee shall

1 receive technical assistance from appropriate Federal
2 agencies.

3 “(c) MEMBERSHIP.—

4 “(1) IN GENERAL.—The committee shall con-
5 sist of 15 members to be appointed by the President
6 not later than 60 days after the date of the enact-
7 ment of this subtitle. The President shall designate
8 1 member as the Chair.

9 “(2) EXPERTISE.—The membership of the com-
10 mittee shall consist of individuals who are of recog-
11 nized standing and distinction and who possess the
12 demonstrated capacity to discharge the duties im-
13 posed on the committee.

14 “(3) TERMS.—Each member of the committee
15 shall be appointed for a term of 5 years, except that
16 the members first appointed shall serve staggered
17 terms such that the terms of no more than 3 mem-
18 bers expire at one time.

19 “(4) VACANCIES.—

20 “(A) IN GENERAL.—A vacancy on the
21 committee shall be filled in the manner in which
22 the original appointment was made and shall be
23 subject to any conditions which applied with re-
24 spect to the original appointment.

1 “(B) FILLING UNEXPIRED TERM.—An in-
2 dividual chosen to fill a vacancy shall be ap-
3 pointed for the unexpired term of the member
4 replaced.

5 “(C) EXPIRATION OF TERMS.—The term
6 of any member shall not expire before the date
7 on which the member’s successor takes office.

8 “(5) CONFLICTS OF INTEREST.—Members of
9 the committee shall disclose upon appointment to
10 the committee or at any subsequent time that it may
11 occur, conflicts of interest.

12 “(d) MEETINGS.—

13 “(1) IN GENERAL.—Except as provided in para-
14 graph (2), the committee shall meet at the call of
15 the Chair.

16 “(2) INITIAL MEETING.—Not later than 30
17 days after the date on which all members of the
18 committee have been appointed, the committee shall
19 hold its first meeting.

20 “(3) QUORUM.—A majority of the members of
21 the committee shall constitute a quorum, but a less-
22 er number of members may hold hearings.

23 “(e) POWER TO HOLD HEARINGS.—The committee
24 may hold such hearings, sit and act at such times and
25 places, take such testimony, and receive such evidence as

1 the committee considers advisable to carry out the pur-
2 poses of this section.

3 “(f) OTHER ADMINISTRATIVE PROVISIONS.—Sub-
4 paragraphs (C), (D), and (H) of section 1886(e)(6) shall
5 apply to the committee in the same manner as they apply
6 to the Prospective Payment Assessment Commission.

7 “(g) REPORTS.—

8 “(1) IN GENERAL.—The committee shall annu-
9 ally prepare and submit to Congress and the Sec-
10 retary a report including at least an analysis of—

11 “(A) the status of the health information
12 network established under this subtitle, includ-
13 ing whether the network is fulfilling the pur-
14 pose described in section 11701;

15 “(B) the savings and costs of the network;

16 “(C) the activities of health information
17 network services certified under section 11741,
18 health care providers, health plans, and other
19 entities using the network to exchange health
20 information;

21 “(D) the extent to which entities described
22 in subparagraph (C) are meeting the standards
23 adopted under this subtitle and working to-
24 gether to form an integrated network that
25 meets the needs of its users;

1 “(E) the extent to which entities described
2 in subparagraph (C) are meeting the privacy
3 and security protections of subtitle C;

4 “(F) the number and types of penalties as-
5 sessed for noncompliance with the standards
6 adopted under this subtitle;

7 “(G) whether the Federal Government and
8 State Governments are receiving information of
9 sufficient quality to meet their responsibilities
10 under the America’s Health Care Option Act;

11 “(H) any problems with respect to imple-
12 mentation of the network;

13 “(I) the extent to which timetables under
14 this subtitle for the adoption and implementa-
15 tion of standards are being met; and

16 “(J) any legislative recommendations relat-
17 ed to the health information network.

18 “(2) AVAILABILITY TO THE PUBLIC.—Any in-
19 formation in the report submitted to Congress under
20 paragraph (1) shall be made available to the public
21 unless such information may not be disclosed by law.

22 “(h) DURATION.—Notwithstanding section 14(a) of
23 the Federal Advisory Committee Act, the committee shall
24 continue in existence until otherwise provided by law.

25 “(i) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) IN GENERAL.—There are authorized to be
2 appropriated such sums as may be necessary to
3 carry out the purposes of this section.

4 “(2) AVAILABILITY.—Any sums appropriated
5 under the authorization contained in this subsection
6 shall remain available, without fiscal year limitation,
7 until expended.

8 **“PART IX—DEMONSTRATION PROJECTS FOR**
9 **COMMUNITY-BASED CLINICAL INFORMATION**
10 **SYSTEMS**

11 **“SEC. 11781. GRANTS FOR DEMONSTRATION PROJECTS.**

12 “(a) IN GENERAL.—The Secretary may make grants
13 for demonstration projects to promote the development
14 and use of electronically integrated community-based clinical
15 information systems and computerized patient medical
16 records.

17 “(b) APPLICATIONS.—

18 “(1) SUBMISSION.—To apply for a grant under
19 this part for any fiscal year, an applicant shall submit
20 an application to the Secretary in accordance
21 with the procedures established by the Secretary.

22 “(2) CRITERIA FOR APPROVAL.—The Secretary
23 may not approve an application submitted under
24 paragraph (1) unless the application includes assur-

ances satisfactory to the Secretary regarding the following:

“(A) USE OF EXISTING TECHNOLOGY.—

Funds received under this part will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

“(B) USE OF EXISTING INFORMATION SYS-

TEMS.—Funds received under this part will be used—

“(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

“(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

“(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

1 “(C) MATCHING FUNDS.—The applicant
2 shall make available funds for the demonstra-
3 tion project in an amount that equals at least
4 20 percent of the cost of the project.

5 “(c) GEOGRAPHIC DIVERSITY.—In making any
6 grants under this part, the Secretary shall, to the extent
7 practicable, make grants to persons representing different
8 geographic areas of the United States, including urban
9 and rural areas.

10 “(d) REVIEW AND SANCTIONS.—The Secretary shall
11 review at least annually the compliance of a person receiv-
12 ing a grant under this part with the provisions of this
13 part. The Secretary shall establish a procedure for deter-
14 mining whether such a person has failed to comply sub-
15 stantially within the provisions of this part and the sanc-
16 tions to be imposed for any such noncompliance.

17 “(e) ANNUAL REPORT.—The Secretary shall submit
18 an annual report to the President for transmittal to Con-
19 gress containing a description of the activities carried out
20 under this part.

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated such sums as may be
23 necessary to carry out the purposes of this section.”.

24 (2) Conforming amendments.—(A) Title XI of
25 the Social Security Act (42 U.S.C. 1301 et seq.) is

1 amended by striking the title and inserting the fol-
 2 lowing:

3 **“TITLE XI—GENERAL PROVI-**
 4 **SIONS, PEER REVIEW, AND**
 5 **ADMINISTRATIVE SIM-**
 6 **PLIFICATION**

7 **“Subtitle A—General Provisions**
 8 **and Peer Review”**

9 (B) Title XI of the Social Security Act (42
 10 U.S.C. 1301 et seq.) is amended by striking each
 11 reference to “this title” and inserting “this subtitle”.

12 (b) MEDICARE AND MEDICAID COVERAGE DATA
 13 BANK AND RELATED IDENTIFICATION PROCESSES.—

14 (1) DELAY OF EMPLOYER REPORTING RE-
 15 QUIREMENT.—

16 (A) IN GENERAL.—Section 1144(c)(1)(A)
 17 of the Social Security Act (42 U.S.C. 1320–
 18 14(c)(1)(A)) is amended by striking “January
 19 1, 1994” and inserting “January 1, 1996”.

20 (B) EFFECTIVE DATE.—The amendment
 21 made by this paragraph shall be effective on the
 22 date of the enactment of this Act.

23 (2) REPEAL OF DATA BANK.—

24 (A) IN GENERAL.—Section 1144 of the So-
 25 cial Security Act (42 U.S.C. 1320b–14) and

1 section 101(f) of the Employee Retirement In-
2 come Security Act of 1974 (29 U.S.C. 1021(f))
3 are repealed.

4 (B) INTERNAL REVENUE CODE PROVI-
5 SION.—Section 6103(l) of the Internal Revenue
6 Code of 1986 is amended by striking paragraph
7 (12).

8 (C) IDENTIFICATION OF MEDICARE SEC-
9 ONDARY PAYER SITUATIONS.—Section 1862(b)
10 of the Social Security Act (42 U.S.C. 1395y(b))
11 is amended by striking paragraph (5).

12 (D) CONFORMING AMENDMENTS.—(i) Sec-
13 tion 1902(a)(25)(A)(i) of the Social Security
14 Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended
15 by striking “including the use of information
16 collected by the Medicare and Medicaid Cov-
17 erage Data Bank under section 1144 and any
18 additional measures”.

19 (ii) Subsection (a)(8)(B) of section 552a of
20 title 5, United States Code, is amended—

21 (I) in clause (v), by inserting “; or” at
22 the end;

23 (II) in clause (vi), by striking “or” at
24 the end; and

25 (III) by striking clause (vii).

1 (E) EFFECTIVE DATE.—The amendments
 2 made by this paragraph apply after the date on
 3 which the health information network estab-
 4 lished under subsection (a) is capable of replac-
 5 ing the activities performed under the provi-
 6 sions affected by such amendments, as certified
 7 by the Secretary of Health and Human Serv-
 8 ices.

9 **SEC. 602. PRIVACY OF HEALTH INFORMATION UNDER THE**
 10 **SOCIAL SECURITY ACT.**

11 (a) IN GENERAL.—Title XI of the Social Security Act
 12 (42 U.S.C. 1301 et seq.), as amended by section 601, is
 13 amended by adding at the end the following new subtitle:

14 **“Subtitle C—Privacy of Health**
 15 **Information**

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- “Sec. 11831. Oversight.
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- “Sec. 11841. Judicial and administrative purposes.
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“SUBPART E—DISCLOSURE PURSUANT TO GOVERNMENT SUBPOENA OR WARRANT

- “Sec. 11851. Government subpoenas and warrants.
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- “Sec. 11854. Private party subpoenas.
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“PART III—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

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“PART V—ADMINISTRATIVE PROVISIONS

“Sec. 11921. Relationship to other laws.

“Sec. 11922. Rights of incompetents.

“Sec. 11923. Exercise of rights.

1 **“PART I—FINDINGS AND DEFINITIONS**

2 **“SEC. 11801. FINDINGS AND PURPOSES.**

3 “(a) FINDINGS.—The Congress finds as follows:

4 “(1) The improper disclosure of individually
5 identifiable health care information may cause sig-
6 nificant harm to an individual’s interests in privacy,
7 health care, and reputation and may unfairly affect
8 the ability of an individual to obtain employment,
9 education, insurance, and credit.

10 “(2) The movement of people and health care
11 related information across State lines, the availabil-
12 ity of, access to, and exchange of health care related
13 information with Federally funded health care sys-
14 tems, the medicare program under title XVIII, and
15 the medicaid program under title XIX, through
16 automated data banks and networks, and the emer-
17 gence of other multistate health care providers and
18 payors create a need for a uniform Federal law gov-
19 erning the disclosure of health care information.

20 “(b) PURPOSE.—The purpose of this subtitle is to es-
21 tablish effective mechanisms to protect the privacy of indi-

1 viduals with respect to individually identifiable health care
 2 information that is created or maintained as part of health
 3 treatment, enrollment, payment, testing, or research proc-
 4 esses.

5 **“SEC. 11802. DEFINITIONS.**

6 “(a) TERMS RELATING TO PROTECTED HEALTH IN-
 7 FORMATION.—In this subtitle:

8 “(1) PROTECTED HEALTH INFORMATION.—The
 9 term ‘protected health information’ means any infor-
 10 mation, including demographic information collected
 11 from an individual, whether oral or recorded in any
 12 form or medium, that—

13 “(A) is created or received by a health care
 14 provider, health plan, health oversight agency,
 15 health researcher, public health authority, em-
 16 ployer, life insurer, school or university, or cer-
 17 tified health information network service; and

18 “(B) relates to the past, present, or future
 19 physical or mental health or condition of an in-
 20 dividual, the provision of health care to an indi-
 21 vidual, or the past, present, or future payment
 22 for the provision of health care to an individual,
 23 and—

24 “(i) identifies an individual; or

1 “(ii) with respect to which there is a
2 reasonable basis to believe that the infor-
3 mation can be used to identify an individ-
4 ual.

5 “(2) DISCLOSE.—The term ‘disclose’, when
6 used with respect to protected health information,
7 means to provide access to the information, but only
8 if such access is provided to a person other than the
9 individual who is the subject of the information.

10 “(b) TERMS RELATING TO HEALTH CARE SYSTEM
11 PARTICIPANTS.—In this subtitle:

12 “(1) HEALTH INFORMATION TRUSTEE.—The
13 term ‘health information trustee’ means—

14 “(A) a health care provider, health plan,
15 health oversight agency, certified health infor-
16 mation network service, employer, life insurer,
17 or school or university insofar as it creates, re-
18 ceives, maintains, uses, or transmits protected
19 health information;

20 “(B) any person who obtains protected
21 health information under section 11823, 11832,
22 11833, 11841, 11842, 11851, or 11854; and

23 “(C) any employee or agent of a person
24 covered under subparagraphs (A) or (B).

25 “(2) HEALTH CARE.—The term ‘health care’—

1 “(A) means—

2 “(i) a preventative, diagnostic, thera-
3 peutic, rehabilitative, maintenance, or pal-
4 liative care, counseling, service, or proce-
5 dure—

6 “(I) with respect to the physical
7 or mental condition of an individual;
8 or

9 “(II) affecting the structure or
10 function of the human body or any
11 part of the human body; or

12 “(ii) any sale or dispensing of a drug,
13 device, equipment, or other item to an indi-
14 vidual, or for the use of an individual, pur-
15 suant to a prescription; but

16 “(B) does not include any item or service
17 that is not furnished for the purpose of examin-
18 ing, maintaining, or improving the health of an
19 individual.

20 “(3) HEALTH CARE PROVIDER.—The term
21 ‘health care provider’ means a person who is li-
22 censed, certified, registered, or otherwise authorized
23 by law to provide an item or service that constitutes
24 health care in the ordinary course of business or
25 practice of a profession.

1 “(4) HEALTH OVERSIGHT AGENCY.—The term
2 ‘health oversight agency’ means a person who—

3 “(A) performs or oversees the performance
4 of an assessment, evaluation, determination, or
5 investigation relating to the licensing, accredita-
6 tion, or certification of health care
7 providers; or

8 “(B)(i) performs or oversees the perform-
9 ance of an assessment, evaluation, determina-
10 tion, or investigation relating to the effective-
11 ness of, compliance with, or applicability of
12 legal, fiscal, medical, or scientific standards or
13 aspects of performance related to the delivery
14 of, or payment for, health care or relating to
15 health care fraud or fraudulent claims for pay-
16 ment regarding health; and

17 “(ii) is a public agency, acting on behalf of
18 a public agency, acting pursuant to a require-
19 ment of a public agency, or carrying out activi-
20 ties under a Federal or State law governing the
21 assessment, evaluation, determination, or inves-
22 tigation described in clause (i).

23 “(5) HEALTH PLAN.—The term ‘health plan’
24 shall have the meaning given such term under sec-
25 tion 11702.

1 “(6) HEALTH RESEARCHER.—The term ‘health
2 researcher’ means a person who conducts a bio-
3 medical, public health, epidemiological, health serv-
4 ices, or health statistics research project or a re-
5 search project on social and behavioral factors relat-
6 ing to health.

7 “(7) INSTITUTIONAL REVIEW BOARD.—The
8 term ‘institutional review board’ means—

9 “(A) a board established in accordance
10 with regulations of the Secretary under section
11 491(a) of the Public Health Service Act;

12 “(B) a similar board established by the
13 Secretary for the protection of human subjects
14 in research conducted by the Secretary; or

15 “(C) a similar board established under reg-
16 ulations of a Federal Government authority
17 other than the Secretary.

18 “(8) PUBLIC HEALTH AUTHORITY.—The term
19 ‘public health authority’ means an authority or in-
20 strumentality of the United States, a State, or a po-
21 litical subdivision of a State that is (A) responsible
22 for public health matters; and (B) engaged in such
23 activities as injury reporting, public health surveil-
24 lance, and public health investigation or interven-
25 tion.

1 “(c) REFERENCES TO CERTIFIED ENTITIES.—In this
2 subtitle:

3 “(1) CERTIFIED HEALTH INFORMATION NET-
4 WORK SERVICE.—The term ‘certified health informa-
5 tion network service’ means a health information
6 service (as defined under section 11702) that is cer-
7 tified under section 11741.

8 “(2) CERTIFIED HEALTH INFORMATION PRO-
9TECTION ORGANIZATION.—The term ‘certified health
10 information protection organization’ means a health
11 information protection organization (as defined in
12 section 11702) that is certified under section 11741.

13 “(d) OTHER TERMS.—In this subtitle:

14 “(1) INDIVIDUAL REPRESENTATIVE.—The term
15 ‘individual representative’ means any individual le-
16 gally empowered to make decisions concerning the
17 provision of health care to an individual (where the
18 individual lacks the legal capacity under State law to
19 make such decisions) or the administrator or execu-
20 tor of the estate of a deceased individual.

21 “(2) LAW ENFORCEMENT INQUIRY.—The term
22 ‘law enforcement inquiry’ means an investigation or
23 official proceeding inquiring into whether there is a
24 violation of, or failure to comply with, any criminal

1 or civil statute or any regulation, rule, or order is-
2 sued pursuant to such a statute.

3 “(3) PERSON.—The term ‘person’ includes an
4 authority of the United States, a State, or a political
5 subdivision of a State.

6 **“PART II—AUTHORIZED DISCLOSURES**

7 **“Subpart A—General Provisions**

8 **“SEC. 11811. GENERAL RULES REGARDING DISCLOSURE.**

9 “(a) GENERAL RULE.—A health information trustee
10 may disclose protected health information only for a pur-
11 pose that is authorized under this subtitle.

12 “(b) DISCLOSURE WITHIN A TRUSTEE.—A health in-
13 formation trustee may disclose protected health informa-
14 tion to an officer, employee, or agent of the trustee, but
15 only for a purpose that is compatible with and related to
16 the purpose for which the information was collected or re-
17 ceived by that trustee.

18 “(c) SCOPE OF DISCLOSURE.—

19 “(1) IN GENERAL.—Every disclosure of pro-
20 tected health information by a health information
21 trustee shall be limited to the minimum amount of
22 information necessary to accomplish the purpose for
23 which the information is disclosed.

24 “(2) REGULATIONS.—The Secretary, after no-
25 tice and opportunity for public comment, may issue

1 regulations under paragraph (1), which shall take
2 into account the technical capabilities of the record
3 systems used to maintain protected health informa-
4 tion and the costs of limiting disclosure.

5 “(d) NO GENERAL REQUIREMENT TO DISCLOSE.—

6 Nothing in this subtitle that permits a disclosure of health
7 information shall be construed to require such disclosure.

8 “(e) USE AND REDISCLOSURE OF INFORMATION.—

9 The protected health information received under a disclo-
10 sure permitted by the subtitle may not be used or disclosed
11 unless the use or disclosure is necessary to fulfill the pur-
12 pose for which the information was obtained and is not
13 otherwise prohibited by law. Protected health information
14 about an individual that is disclosed under this subtitle
15 may not be used in, or disclosed to any person for use
16 in, any administrative, civil, or criminal action or inves-
17 tigation directed against the individual unless specifically
18 permitted by this subtitle.

19 “(f) IDENTIFICATION OF DISCLOSED INFORMATION
20 AS PROTECTED INFORMATION.—

21 “(1) IN GENERAL.—Except with respect to pro-
22 tected health information that is disclosed under sec-
23 tion 11823 and except as provided in paragraph (2),
24 a health information trustee may not disclose pro-
25 tected health information unless such information is

1 clearly identified as protected health information
2 that is subject to this subtitle.

3 “(2) ROUTINE DISCLOSURES SUBJECT TO WRIT-
4 TEN AGREEMENT.—A health information trustee
5 who routinely discloses protected health information
6 to a person may satisfy the identification require-
7 ment in paragraph (1) through a written agreement
8 between the trustee and the person with respect to
9 the protected health information.

10 “(g) CONSTRUCTION.—Nothing in this subtitle shall
11 be construed to limit the ability of a health information
12 trustee to charge a reasonable fee for the disclosure or
13 reproduction of health information.

14 “(h) INFORMATION IN WHICH PROVIDERS ARE IDEN-
15 TIFIED.—The Secretary, after notice and opportunity for
16 public comment, may issue regulations protecting informa-
17 tion identifying providers in order to promote the availabil-
18 ity of health care services.

19 **“SEC. 11812. AUTHORIZATIONS FOR DISCLOSURE OF PRO-**
20 **TECTED HEALTH INFORMATION.**

21 “(a) WRITTEN AUTHORIZATIONS.—A health infor-
22 mation trustee may disclose protected health information
23 pursuant to an authorization executed by the individual
24 who is the subject of the information, if each of the follow-
25 ing requirements is met:

1 “(1) WRITING.—The authorization is in writ-
2 ing, signed by the individual who is the subject of
3 the information, and dated on the date of such sig-
4 nature.

5 “(2) SEPARATE FORM.—The authorization is
6 not on a form used to authorize or facilitate the pro-
7 vision of, or payment for, health care.

8 “(3) TRUSTEE DESCRIBED.—The trustee is
9 specifically named or generically described in the au-
10 thorization as authorized to disclose such informa-
11 tion.

12 “(4) RECIPIENT DESCRIBED.—The person to
13 whom the information is to be disclosed is specifi-
14 cally named or generically described in the author-
15 ization as a person to whom such information may
16 be disclosed.

17 “(5) STATEMENT OF INTENDED DISCLO-
18 SURES.—The authorization contains an acknowledg-
19 ment that the individual who is the subject of the in-
20 formation has read a statement of the disclosures
21 that the person to receive the protected health infor-
22 mation intends to make, which statement shall be in
23 writing, on a form that is distinct from the author-
24 ization for disclosure, and which statement must be

1 received by the individual authorizing the disclosure
2 on or before such authorization is executed.

3 “(6) INFORMATION DESCRIBED.—The informa-
4 tion to be disclosed is described in the authorization.

5 “(7) EXPIRATION DATE SPECIFIED.—The au-
6 thorization specifies a date or event upon which the
7 authorization expires, which shall not exceed 2 years
8 from the date of the execution of the authorization.

9 “(8) AUTHORIZATION TIMELY RECEIVED.—The
10 authorization is received by the trustee during a pe-
11 riod described in subsection (b)(1).

12 “(9) DISCLOSURE TIMELY MADE.—The disclo-
13 sure occurs during a period described in subsection
14 (b)(2).

15 “(b) TIME LIMITATIONS ON AUTHORIZATIONS.—

16 “(1) RECEIPT BY TRUSTEE.—For purposes of
17 subsection (a)(8), an authorization is timely received
18 if it is received by the trustee during—

19 “(A) the 1-year period beginning on the
20 date on which the authorization is signed under
21 subsection (a)(1), if the authorization permits
22 the disclosure of protected health information to
23 a person who provides health counseling or so-
24 cial services to individuals; or

1 “(B) the 30-day period beginning on the
2 date on which the authorization is signed under
3 subsection (a)(1), if the authorization permits
4 the disclosure of protected health information to
5 a person other than a person described in sub-
6 paragraph (A).

7 “(2) DISCLOSURE BY TRUSTEE.—For purposes
8 of subsection (a)(9), a disclosure is timely made if
9 it occurs before the date or event specified in the au-
10 thorization upon which the authorization expires.

11 “(c) REVOCATION OR AMENDMENT OF AUTHORIZA-
12 TION.—

13 “(1) IN GENERAL.—An individual may in writ-
14 ing revoke or amend an authorization described in
15 subsection (a), in whole or in part, at any time, ex-
16 cept when—

17 “(A) disclosure of protected health infor-
18 mation has been authorized to permit validation
19 of expenditures for health care; or

20 “(B) action has been taken in reliance on
21 the authorization.

22 “(2) NOTICE OF REVOCATION.—A health infor-
23 mation trustee who discloses protected health infor-
24 mation pursuant to an authorization that has been

1 revoked shall not be subject to any liability or pen-
2 alty under this subtitle if—

3 “(A) the reliance was in good faith;

4 “(B) the trustee had no notice of the rev-
5 ocation; and

6 “(C) the disclosure was otherwise in ac-
7 cordance with the requirements of this subtitle.

8 “(d) DECEASED INDIVIDUAL.—The Secretary shall
9 develop and establish through regulation a procedure for
10 obtaining protected health information relating to a de-
11 ceased individual when there is no individual representa-
12 tive for such individual.

13 “(e) MODEL AUTHORIZATIONS.—The Secretary,
14 after notice and opportunity for public comment, shall de-
15 velop and disseminate model written authorizations of the
16 type described in subsection (a) and model statements of
17 intended disclosures of the type described in subsection
18 (a)(5).

19 “(f) COPY.—A health information trustee who dis-
20 closes protected health information pursuant to an author-
21 ization under this section shall maintain a copy of the au-
22 thorization.

1 **“SEC. 11813. CERTIFIED HEALTH INFORMATION NETWORK**
2 **SERVICES.**

3 “(a) IN GENERAL.—A health information trustee
4 may disclose protected health information to a certified
5 health information network service acting as an agent of
6 the trustee for any purpose permitted by this subtitle.
7 Such a service, acting as an agent of a trustee, may dis-
8 close protected health information to another person as
9 permitted under this subtitle to facilitate the completion
10 of the purpose for which such information was disclosed
11 to the service.

12 “(b) CERTIFIED HEALTH INFORMATION PROTEC-
13 TION ORGANIZATIONS.—A health information trustee may
14 disclose protected health information to a certified health
15 information protection organization for the purpose of cre-
16 ating non-identifiable health information (as defined in
17 section 11702).

18 **“Subpart B—Specific Disclosures Relating to Patient**
19 **“SEC. 11821. DISCLOSURES FOR TREATMENT AND FINAN-**
20 **CIAL AND ADMINISTRATIVE TRANSACTIONS.**

21 “(a) HEALTH CARE TREATMENT.—A health care
22 provider, health plan, employer, or person who receives
23 protected health information under section 11823, may
24 disclose protected health information to a health care pro-
25 vider for the purpose of providing health care to an indi-
26 vidual if the individual who is the subject of the informa-

1 tion has not previously objected in writing to the disclo-
2 sure.

3 “(b) DISCLOSURE TO HEALTH PLANS FOR FINAN-
4 CIAL AND ADMINISTRATIVE PURPOSES.—A health care
5 provider or employer may disclose protected health infor-
6 mation to a health plan for the purpose of providing for
7 the payment for, or reviewing the payment of, health care
8 furnished to an individual.

9 “(c) DISCLOSURE BY HEALTH PLANS FOR FINAN-
10 CIAL AND ADMINISTRATIVE PURPOSES.—A health plan
11 may disclose protected health information to a health care
12 provider or a health plan for the purpose of providing for
13 the payment for, or reviewing the payment of, health care
14 furnished to an individual.

15 **“SEC. 11822. NEXT OF KIN AND DIRECTORY INFORMATION.**

16 “(a) NEXT OF KIN.—A health care provider or per-
17 son who receives protected health information under sec-
18 tion 11823 may disclose protected health information to
19 the next of kin, an individual representative of the individ-
20 ual who is the subject of the information, or an individual
21 with whom that individual has a close personal relation-
22 ship if—

23 “(1) the individual who is the subject of the in-
24 formation—

1 “(A) has been notified of the individual’s
2 right to object and has not objected to the dis-
3 closure;

4 “(B) is not competent to be notified about
5 the right to object; or

6 “(C) exigent circumstances exist such that
7 it would not be practicable to notify the individ-
8 ual of the right to object; and

9 “(2) the information disclosed relates to health
10 care currently being provided to that individual.

11 “(b) DIRECTORY INFORMATION.—A health care pro-
12 vider and a person receiving protected health information
13 under section 11823 may disclose protected health infor-
14 mation to any person if—

15 “(1) the information does not reveal specific in-
16 formation about the physical or mental condition of
17 the individual who is the subject of the information
18 or health care provided to that person;

19 “(2) the individual who is the subject of the in-
20 formation—

21 “(A) has been notified of the individual’s
22 right to object and has not objected to the dis-
23 closure;

24 “(B) is not competent to be notified about
25 the right to object; or

1 “(C) exigent circumstances exist such that
 2 it would not be practicable to notify the individ-
 3 ual of the right to object; and

4 “(3) the information consists only of 1 or more
 5 of the following items:

6 “(A) The name of the individual who is the
 7 subject of the information.

8 “(B) If the individual who is the subject of
 9 the information is receiving health care from a
 10 health care provider on a premises controlled by
 11 the provider—

12 “(i) the location of the individual on
 13 the premises; and

14 “(ii) the general health status of the
 15 individual, described as critical, poor, fair,
 16 stable, or satisfactory or in terms denoting
 17 similar conditions.

18 “(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—
 19 A health care provider, health plan, employer, or life in-
 20 surer, may disclose protected health information if nec-
 21 essary to assist in the identification of a deceased individ-
 22 ual.

23 **“SEC. 11823. EMERGENCY CIRCUMSTANCES.**

24 “(a) IN GENERAL.—A health care provider, health
 25 plan, employer, or person who receives protected health

1 information under this section may disclose protected
2 health information in emergency circumstances when nec-
3 essary to protect the health or safety of an individual from
4 imminent harm.

5 “(b) SCOPE OF DISCLOSURE.—The disclosure of pro-
6 tected health information under this section shall be lim-
7 ited to persons who need the information to take action
8 to protect the health or safety of the individual.

9 **“Subpart C—Disclosure for Oversight, Public Health,**
10 **and Research Purposes**

11 **“SEC. 11831. OVERSIGHT.**

12 “(a) IN GENERAL.—A health information trustee
13 may disclose protected health information to a health over-
14 sight agency for an oversight function authorized by law.

15 “(b) USE IN ACTION AGAINST INDIVIDUALS.—Not-
16 withstanding section 11811(e), protected health informa-
17 tion about an individual that is disclosed under this sec-
18 tion may be used in, or disclosed to any person for use
19 in, any administrative, civil, or criminal action or inves-
20 tigation directed against the individual who is the subject
21 of the information if the action or investigation arises out
22 of and is directly related to receipt of health care or pay-
23 ment for health care or an action involving a fraudulent
24 claim related to health.

1 **“SEC. 11832. PUBLIC HEALTH.**

2 “A health care provider, health plan, public health
3 authority, employer, or person who receives protected
4 health information under section 11823 may disclose pro-
5 tected health information to a public health authority or
6 other person authorized by law for use in a legally author-
7 ized—

8 “(1) disease or injury reporting;

9 “(2) public health surveillance; or

10 “(3) public health investigation or intervention.

11 **“SEC. 11833. HEALTH RESEARCH.**

12 “(a) IN GENERAL.—A health information trustee
13 may disclose protected health information to a health re-
14 searcher if an institutional review board determines that
15 the research project engaged in by the health researcher—

16 “(1) requires use of the protected health infor-
17 mation for the effectiveness of the project; and

18 “(2) is of sufficient importance to outweigh the
19 intrusion into the privacy of the individual who is
20 the subject of the information that would result from
21 the disclosure.

22 “(b) RESEARCH REQUIRING DIRECT CONTACT.—A
23 health information trustee may disclose protected health
24 information to a health researcher for a research project
25 that includes direct contact with an individual who is the

1 subject of protected health information if an institutional
2 review board determines that—

3 “(1) the research project meets the require-
4 ments of paragraphs (1) and (2) of subsection (a);

5 “(2) direct contact is necessary to accomplish
6 the research purpose; and

7 “(3) the direct contact will be made in a man-
8 ner that minimizes the risk of harm, embarrassment,
9 or other adverse consequences to the individual.

10 “(c) USE OF HEALTH INFORMATION NETWORK.—

11 “(1) IN GENERAL.—A health information trust-
12 ee may disclose protected health information to a
13 health researcher using the health information net-
14 work (as defined in section 11702) only if an institu-
15 tional review board certified by the Secretary under
16 paragraph (2) determines that the research project
17 engaged in by the health researcher meets the re-
18 quirements of this section.

19 “(2) CERTIFICATION OF INSTITUTIONAL RE-
20 VIEW BOARDS.—

21 “(A) REGULATIONS.—The Secretary, after
22 notice and opportunity for public comment,
23 shall issue regulations establishing certification
24 requirements for institutional review boards
25 under this subtitle. Such regulations shall be

1 based on regulations issued under section
2 491(a) of the Public Health Service Act and
3 shall ensure that institutional review boards
4 certified under this paragraph have the quali-
5 fications to access and protect the confidential-
6 ity of research subjects.

7 “(B) CERTIFICATION.—The Secretary
8 shall certify an institutional review board that
9 meets the certification requirements established
10 by the Secretary under subparagraph (A).

11 “(d) OBLIGATIONS OF RECIPIENT.—A person who
12 receives protected health information pursuant to sub-
13 section (a)—

14 “(1) shall remove or destroy, at the earliest op-
15 portunity consistent with the purposes of the project,
16 information that would enable an individual to be
17 identified, unless—

18 “(A) an institutional review board has de-
19 termined that there is a health or research jus-
20 tification for retention of such identifiers; and

21 “(B) there is an adequate plan to protect
22 the identifiers from disclosure that is inconsis-
23 tent with this section; and

1 “(2) shall use protected health information sole-
2 ly for purposes of the health research project for
3 which disclosure was authorized under this section.

4 **“Subpart D—Disclosure For Judicial, Administrative,**
5 **and Law Enforcement Purposes**

6 **“SEC. 11841. JUDICIAL AND ADMINISTRATIVE PURPOSES.**

7 A health care provider, health plan, health oversight
8 agency, or employer may disclose protected health infor-
9 mation—

10 “(1) pursuant to the Federal Rules of Civil
11 Procedure, the Federal Rules of Criminal Procedure,
12 or comparable rules of other courts or administrative
13 agencies in connection with litigation or proceedings
14 to which the individual who is the subject of the in-
15 formation is a party and in which the individual has
16 placed the individual’s physical or mental condition
17 in issue;

18 “(2) to a court, and to others ordered by a
19 court, if the protected health information is devel-
20 oped in response to a court-ordered physical or men-
21 tal examination; or

22 “(3) pursuant to a law requiring the reporting
23 of specific medical information to law enforcement
24 authorities.

1 **“SEC. 11842. LAW ENFORCEMENT.**

2 “(a) IN GENERAL.—A health care provider, health
3 plan, health oversight agency, employer, or person who re-
4 ceives protected health information under section 11823
5 may disclose protected health information to a law en-
6 forcement agency (other than a health oversight agency
7 governed by section 11831) if the information is requested
8 for use—

9 “(1) in an investigation or prosecution of a
10 health information trustee;

11 “(2) in the identification of a victim or witness
12 in a law enforcement inquiry; or

13 “(3) in connection with the investigation of
14 criminal activity committed against the trustee or on
15 premises controlled by the trustee.

16 “(b) CERTIFICATION.—When a law enforcement
17 agency (other than a health oversight agency) requests
18 that a health information trustee disclose protected health
19 information under this section, the law enforcement agen-
20 cy shall provide the trustee with a written certification
21 that—

22 “(1) specifies the information requested;

23 “(2) states that the information is needed for a
24 lawful purpose under this section; and

25 “(3) is signed by a supervisory official of a rank
26 designated by the head of the agency.

1 “(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—
 2 Notwithstanding section 11811(e), protected health infor-
 3 mation about an individual that is disclosed to a law en-
 4 forcement agency under this section may be used in, or
 5 disclosed for, an administrative, civil, or criminal action
 6 or investigation against the individual if the action or in-
 7 vestigation arises out of and is directly related to the ac-
 8 tion or investigation for which the information was ob-
 9 tained.

10 **“Subpart E—Disclosure Pursuant to Government**
 11 **Subpoena or Warrant**

12 **“SEC. 11851. GOVERNMENT SUBPOENAS AND WARRANTS.**

13 “(a) IN GENERAL.—A health care provider, health
 14 plan, health oversight agency, employer, or person who re-
 15 ceives protected health information under section 11823
 16 may disclose protected health information under this sec-
 17 tion if the disclosure is pursuant to—

18 “(1) a subpoena issued under the authority of
 19 a grand jury, and the trustee is provided a written
 20 certification by the grand jury seeking the informa-
 21 tion that the grand jury has complied with the appli-
 22 cable access provisions of section 11852;

23 “(2) an administrative subpoena or a judicial
 24 subpoena or warrant, and the trustee is provided a
 25 written certification by the person seeking the infor-

1 mation that the person has complied with the appli-
2 cable access provisions of section 11852; or

3 “(3) an administrative subpoena or a judicial
4 subpoena or warrant, and the disclosure otherwise
5 meets the conditions of section 11831, 11832,
6 11841, or 11842.

7 “(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

8 “(1) ACTIONS OR INVESTIGATIONS.—Notwith-
9 standing section 11811(c), protected health informa-
10 tion about an individual that is received under sub-
11 section (a) may be disclosed for, or used in, any ad-
12 ministrative, civil, or criminal action or investigation
13 against the individual if the action or investigation
14 arises out of and is directly related to the inquiry for
15 which the information was obtained.

16 “(2) SPECIAL RULE.—Protected health infor-
17 mation about an individual that is received under
18 subsection (a)(3) may not be disclosed by the recipi-
19 ent unless the recipient complies with the conditions
20 and restrictions on disclosure with which the recipi-
21 ent would have been required to comply if the disclo-
22 sure had been made under section 11831, 11832,
23 11841, or 11842.

1 **“SEC. 11852. ACCESS PROCEDURES FOR LAW ENFORCE-**
2 **MENT SUBPOENAS AND WARRANTS.**

3 “(a) PROBABLE CAUSE REQUIREMENT.—A govern-
4 ment authority may not obtain protected health informa-
5 tion about an individual under paragraph (1) or (2) of
6 section 11851(a) for use in a law enforcement inquiry un-
7 less there is probable cause to believe that the information
8 is relevant to a legitimate law enforcement inquiry being
9 conducted by the government authority.

10 “(b) WARRANTS.—A government authority that ob-
11 tains protected health information about an individual
12 under circumstances described in subsection (a) and pur-
13 suant to a warrant shall, not later than 30 days after the
14 date the warrant was executed, serve the individual with,
15 or mail to the last known address of the individual, a no-
16 tice that protected health information about the individual
17 was so obtained, together with a notice of the individual’s
18 right to challenge the warrant in accordance with section
19 11853.

20 “(c) SUBPOENAS.—Except as provided in subsection
21 (d), a government authority may not obtain protected
22 health information about an individual under cir-
23 cumstances described in subsection (a) and pursuant to
24 a subpoena unless a copy of the subpoena has been served
25 on the individual on or before the date of return of the
26 subpoena, together with a notice of the individual’s right

1 to challenge the subpoena in accordance with section
2 11853, and—

3 “(1) 30 days have passed since the date of serv-
4 ice on the individual and within that time period the
5 individual has not initiated a challenge in accordance
6 with section 11853; or

7 “(2) disclosure is ordered by a court after chal-
8 lenge under section 11853.

9 “(d) APPLICATION FOR DELAY.—

10 “(1) IN GENERAL.—A government authority
11 may apply ex parte and under seal to an appropriate
12 court to delay (for an initial period of not longer
13 than 90 days) serving a notice or copy of a subpoena
14 required under subsection (b) or (c) with respect to
15 a law enforcement inquiry. The government author-
16 ity may apply to the court for extensions of the
17 delay.

18 “(2) REASONS FOR DELAY.—An application for
19 a delay, or extension of a delay, under this sub-
20 section shall state, with reasonable specificity, the
21 reasons why the delay or extension is being sought.

22 “(3) EX PARTE ORDER.—The court shall enter
23 an ex parte order delaying or extending the delay of
24 notice, an order prohibiting the disclosure of the re-
25 quest for, or disclosure of, the protected health in-

1 formation, and an order requiring the disclosure of
2 the protected health information if the court finds
3 that—

4 “(A) the inquiry being conducted is within
5 the lawful jurisdiction of the government au-
6 thority seeking the protected health informa-
7 tion;

8 “(B) there is probable cause to believe that
9 the protected health information being sought is
10 relevant to a legitimate law enforcement in-
11 quiry;

12 “(C) the government authority’s need for
13 the information outweighs the privacy interest
14 of the individual who is the subject of the infor-
15 mation; and

16 “(D) there is reasonable ground to believe
17 that receipt of notice by the individual will re-
18 sult in—

19 “(i) endangering the life or physical
20 safety of any individual;

21 “(ii) flight from prosecution;

22 “(iii) destruction of or tampering with
23 evidence or the information being sought;
24 or

1 “(iv) intimidation of potential wit-
2 nesses.

3 **“SEC. 11853. CHALLENGE PROCEDURES FOR LAW EN-**
4 **FORCEMENT WARRANTS AND SUBPOENAS.**

5 “(a) MOTION TO QUASH.—Within 30 days after the
6 date of service of a notice of execution or a copy of a sub-
7 poena of a government authority seeking protected health
8 information about an individual under paragraph (1) or
9 (2) of section 11851(a), the individual may file a motion
10 to quash—

11 “(1) in the case of a State judicial warrant or
12 subpoena, in the court which issued the warrant or
13 subpoena;

14 “(2) in the case of a warrant or subpoena is-
15 sued under the authority of a State that is not a
16 State judicial warrant or subpoena, in a court of
17 competent jurisdiction; or

18 “(3) in the case of any other warrant or sub-
19 poena issued under the authority of a Federal court
20 or the United States, in the United States district
21 court for the district in which the individual resides
22 or in which the warrant or subpoena was issued.

23 “(b) COPY.—A copy of the motion shall be served by
24 the individual upon the government authority by reg-
25 istered or certified mail.

1 “(c) PROCEEDINGS.—The government authority may
2 file with the court such papers, including affidavits and
3 other sworn documents, as sustain the validity of the war-
4 rant or subpoena. The individual may file with the court
5 reply papers in response to the government authority’s fil-
6 ing. The court, upon the request of the individual or the
7 government authority or both, may proceed in camera.
8 The court may conduct such proceedings as it deems ap-
9 propriate to rule on the motion, but shall endeavor to ex-
10 pedite its determination.

11 “(d) STANDARD FOR DECISION.—A court may deny
12 a motion under subsection (a) if it finds there is probable
13 cause to believe the protected health information is rel-
14 evant to a legitimate law enforcement inquiry being con-
15 ducted by the government authority, unless the court finds
16 the individual’s privacy interest outweighs the government
17 authority’s need for the information. The individual shall
18 have the burden of demonstrating that the individual’s pri-
19 vacy interest outweighs the need by the government au-
20 thority for the information.

21 “(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO
22 PRIVACY INTEREST.—In reaching its determination, the
23 court shall consider—

24 “(1) the particular purpose for which the infor-
25 mation was collected;

1 “(2) the degree to which disclosure of the infor-
2 mation will embarrass, injure, or invade the privacy
3 of the individual;

4 “(3) the effect of the disclosure on the individ-
5 ual’s future health care;

6 “(4) the importance of the inquiry being con-
7 ducted by the government authority, and the impor-
8 tance of the information to that inquiry; and

9 “(5) any other factor deemed relevant by the
10 court.

11 “(f) ATTORNEY’S FEES.—In the case of a motion
12 brought under subsection (a) in which the individual has
13 substantially prevailed, the court may assess against the
14 government authority a reasonable attorney’s fee and
15 other litigation costs (including expert’s fees) reasonably
16 incurred.

17 “(g) NO INTERLOCUTORY APPEAL.—A ruling deny-
18 ing a motion to quash under this section shall not be
19 deemed to be a final order, and no interlocutory appeal
20 may be taken therefrom by the individual. An appeal of
21 such a ruling may be taken by the individual within such
22 period of time as is provided by law as part of any appeal
23 from a final order in any legal proceeding initiated against
24 the individual arising out of or based upon the protected
25 health information disclosed.

1 **“Subpart F—Disclosure Pursuant to Private Party**
2 **Subpoena**

3 **“SEC. 11854. PRIVATE PARTY SUBPOENAS.**

4 “A health care provider, health plan, employer, or
5 person who receives protected health information under
6 section 11823 may disclose protected health information
7 under this section if the disclosure is pursuant to a sub-
8 poena issued on behalf of a private party who has complied
9 with the access provisions of section 11855.

10 **“SEC. 11855. ACCESS PROCEDURES FOR PRIVATE PARTY**
11 **SUBPOENAS.**

12 “A private party may not obtain protected health in-
13 formation about an individual pursuant to a subpoena un-
14 less a copy of the subpoena together with a notice of the
15 individual’s right to challenge the subpoena in accordance
16 with section 11856 has been served upon the individual
17 on or before the date of return of the subpoena, and—

18 “(1) 30 days have passed since the date of serv-
19 ice on the individual, and within that time period the
20 individual has not initiated a challenge in accordance
21 with section 11856; or

22 “(2) disclosure is ordered by a court under sec-
23 tion 11856.

1 **“SEC. 11856. CHALLENGE PROCEDURES FOR PRIVATE**
2 **PARTY SUBPOENAS.**

3 “(a) MOTION TO QUASH SUBPOENA.—Within 30
4 days after service of a copy of the subpoena seeking pro-
5 tected health information under section 11854, the indi-
6 vidual who is the subject of the protected health informa-
7 tion may file in any court of competent jurisdiction a mo-
8 tion to quash the subpoena and serve a copy of the motion
9 on the person seeking the information.

10 “(b) STANDARD FOR DECISION.—The court shall
11 grant a motion under subsection (a) unless the respondent
12 demonstrates that—

13 “(1) there is reasonable ground to believe the
14 information is relevant to a lawsuit or other judicial
15 or administrative proceeding; and

16 “(2) the need of the respondent for the infor-
17 mation outweighs the privacy interest of the individ-
18 ual.

19 “(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO
20 PRIVACY INTEREST.—In determining under subsection
21 (b) whether the need of the respondent for the information
22 outweighs the privacy interest of the individual, the court
23 shall consider—

24 “(1) the particular purpose for which the infor-
25 mation was collected;

1 “(2) the degree to which disclosure of the infor-
2 mation would embarrass, injure, or invade the pri-
3 vacy of the individual;

4 “(3) the effect of the disclosure on the individ-
5 ual’s future health care;

6 “(4) the importance of the information to the
7 lawsuit or proceeding; and

8 “(5) any other relevant factor.

9 “(d) ATTORNEY’S FEES.—In the case of a motion
10 brought under subsection (a) in which the individual has
11 substantially prevailed, the court may assess against the
12 respondent a reasonable attorney’s fee and other litigation
13 costs and expenses (including expert’s fees) reasonably in-
14 curred.

15 **“PART III—PROCEDURES FOR ENSURING SECU-**
16 **RITY OF PROTECTED HEALTH INFORMATION**

17 **“Subpart A—Establishment of Safeguards**

18 **“SEC. 11861. ESTABLISHMENT OF SAFEGUARDS.**

19 “(a) IN GENERAL.—A health information trustee
20 shall establish and maintain appropriate administrative,
21 technical, and physical safeguards—

22 “(1) to ensure the integrity and confidentiality
23 of protected health information created or received
24 by the trustee; and

1 “(2) to protect against any anticipated threats
2 or hazards to the security or integrity of such infor-
3 mation.

4 “(b) REGULATIONS.—The Secretary shall promul-
5 gate regulations regarding security measures for protected
6 health information. In developing such regulations, the
7 Secretary shall consult with appropriate private parties
8 with expertise in safeguarding health information.

9 **“SEC. 11862. ACCOUNTING FOR DISCLOSURES.**

10 “(a) IN GENERAL.—

11 “(1) REQUIREMENT TO CREATE OR MAINTAIN
12 RECORD.—A health information trustee shall create
13 and maintain, with respect to any protected health
14 information disclosed in exceptional circumstances
15 (as described in paragraph (2)), a record of—

16 “(A) the date and purpose of the disclo-
17 sure;

18 “(B) the name of the person to whom or
19 to which the disclosure was made;

20 “(C) the address of the person to whom or
21 to which the disclosure was made or the loca-
22 tion to which the disclosure was made; and

23 “(D) the information disclosed, if the re-
24 cording of the information disclosed is prac-
25 ticable, taking into account the technical capa-

1 bilities of the system used to maintain the
2 record and the costs of such maintenance.

3 “(2) EXCEPTIONAL CIRCUMSTANCES DE-
4 SCRIBED.—For purposes of paragraph (1) protected
5 health information is disclosed in exceptional cir-
6 cumstances if the disclosure—

7 “(A) is not a routine part of doing busi-
8 ness, as determined in accordance with guide-
9 lines promulgated by the Secretary; or

10 “(B) is permitted under sections 11823
11 and 11832.

12 “(b) DISCLOSURE RECORD PART OF INFORMATION.—
13 A record created and maintained under paragraph (a)
14 shall be maintained as part of the protected health infor-
15 mation to which the record pertains.

16 **“Subpart B—Review of Protected Health Information**
17 **By Subjects of the Information**

18 **“SEC. 11871. INSPECTION OF PROTECTED HEALTH INFOR-**
19 **MATION.**

20 “(a) IN GENERAL.—Except as provided in subsection
21 (c), a health care provider or health plan—

22 “(1) shall permit an individual who is the sub-
23 ject of protected health information to inspect any
24 such information that the provider or plan main-
25 tains;

1 “(2) shall permit the individual to have a copy
2 of the information;

3 “(3) shall permit a person who has been des-
4 ignated in writing by the individual who is the sub-
5 ject of the information to inspect the information on
6 behalf of the individual or to accompany the individ-
7 ual during the inspection; and

8 “(4) may offer to explain or interpret informa-
9 tion that is inspected or copied under this sub-
10 section.

11 “(b) ADDITIONAL REQUESTS.—Except as provided in
12 subsection (c), a health plan or health care provider shall,
13 upon written request of an individual—

14 “(1) determine the identity of previous provid-
15 ers to the individual; and

16 “(2) obtain protected health information re-
17 garding the individual.

18 “(c) EXCEPTIONS.—A health care provider or health
19 plan is not required by this section to permit inspection
20 or copying of protected health information if any of the
21 following conditions apply:

22 “(1) MENTAL HEALTH TREATMENT NOTES.—
23 The information consists of psychiatric, psycho-
24 logical, or mental health treatment notes, and the
25 provider or plan determines, based on reasonable

1 medical judgment, that inspection or copying of the
2 notes would cause sufficient harm to the individual
3 who is the subject of the notes so as to outweigh the
4 desirability of permitting access, and the provider or
5 plan has not disclosed the notes to any person not
6 directly engaged in treating the individual, except
7 with the authorization of the individual or under
8 compulsion of law.

9 “(2) INFORMATION ABOUT OTHERS.—The in-
10 formation relates to an individual other than the in-
11 dividual seeking to inspect or have a copy of the in-
12 formation and the provider or plan determines,
13 based on reasonable medical judgment, that inspec-
14 tion or copying of the information would cause suffi-
15 cient harm to 1 or both of the individuals so as to
16 outweigh the desirability of permitting access.

17 “(3) ENDANGERMENT TO LIFE OR SAFETY.—
18 The provider or plan determines that disclosure of
19 the information could reasonably be expected to en-
20 danger the life or physical safety of any individual.

21 “(4) CONFIDENTIAL SOURCE.—The information
22 identifies or could reasonably lead to the identifica-
23 tion of a person (other than a health care provider)
24 who provided information under a promise of con-

1 confidentiality to a health care provider concerning the
2 individual who is the subject of the information.

3 “(5) ADMINISTRATIVE PURPOSES.—The infor-
4 mation—

5 “(A) is used by the provider or plan solely
6 for administrative purposes and not in the pro-
7 vision of health care to the individual who is the
8 subject of the information; and

9 “(B) has not been disclosed by the pro-
10 vider or plan to any other person.

11 “(d) INSPECTION AND COPYING OF SEGREGABLE
12 PORTION.—A health care provider or health plan shall
13 permit inspection and copying under subsection (a) of any
14 reasonably segregable portion of a record after deletion of
15 any portion that is exempt under subsection (c).

16 “(e) CONDITIONS.—A health care provider or health
17 plan may require a written request for the inspection and
18 copying of protected health information under this sub-
19 section. The health care provider or health plan may re-
20 quire a reasonable cost reimbursement for such inspection
21 and copying.

22 “(f) STATEMENT OF REASONS FOR DENIAL.—If a
23 health care provider or health plan denies a request for
24 inspection or copying under this section, the provider or
25 plan shall provide the individual who made the request (or

1 the individual's designated representative) with a written
2 statement of the reasons for the denial.

3 “(g) DEADLINE.—A health care provider or health
4 plan shall comply with or deny a request for inspection
5 or copying of protected health information under this sec-
6 tion within the 30-day period beginning on the date on
7 which the provider or plan receives the request.

8 **“SEC. 11872. AMENDMENT OF PROTECTED HEALTH INFOR-**
9 **MATION.**

10 “(a) IN GENERAL.—A health care provider or health
11 plan shall, within the 45-day period beginning on the date
12 on which the provider or plan receives from an individual
13 a written request that the provider or plan correct or
14 amend the information—

15 “(1) make the correction or amendment re-
16 quested;

17 “(2) inform the individual of the correction or
18 amendment that has been made; and

19 “(3) inform any person who is identified by the
20 individual, who is not an officer, employee or agent
21 of the provider or plan, and to whom the uncor-
22 rected or unamended portion of the information was
23 previously disclosed, of the correction or amendment
24 that has been made.

1 “(b) REFUSAL TO CORRECT.—If the provider or plan
2 refuses to make the corrections, the provider or plan shall
3 inform the individual of—

4 “(1) the reasons for the refusal of the provider
5 or plan to make the correction or amendment;

6 “(2) any procedures for further review of the
7 refusal; and

8 “(3) the individual’s right to file with the pro-
9 vider or plan a concise statement setting forth the
10 requested correction or amendment and the individ-
11 ual’s reasons for disagreeing with the refusal of the
12 provider or plan.

13 “(c) BASES FOR REQUEST TO CORRECT OR AMEND.—
14 An individual may request correction or amendment of
15 protected health information about the individual under
16 paragraph (a) if the information is not timely, accurate,
17 relevant to the system of records, or complete.

18 “(d) STATEMENT OF DISAGREEMENT.—After an in-
19 dividual has filed a statement of disagreement under para-
20 graph (b)(3), the provider or plan, in any subsequent dis-
21 closure of the disputed portion of the information—

22 “(1) shall include a copy of the individual’s
23 statement; and

1 “(2) may include a concise statement of the
2 reasons of the provider or plan for not making the
3 requested correction or amendment.

4 “(e) RULE OF CONSTRUCTION.—This section shall
5 not be construed to require a health care provider or
6 health plan to conduct a formal, informal, or other hearing
7 or proceeding concerning a request for a correction or
8 amendment to protected health information the provider
9 or plan maintains.

10 “(f) CORRECTION.—For purposes of paragraph (a),
11 a correction is deemed to have been made to protected
12 health information when information that is not timely,
13 accurate, relevant to the system of records, or complete
14 is clearly marked as incorrect or when supplementary cor-
15 rect information is made part of the information.

16 **“SEC. 11873. NOTICE OF INFORMATION PRACTICES.**

17 “(a) PREPARATION OF WRITTEN NOTICE.—A health
18 care provider or health plan shall prepare a written notice
19 of information practices describing the following:

20 “(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—
21 The rights under this subpart of an individual who
22 is the subject of protected health information, in-
23 cluding the right to inspect and copy such informa-
24 tion and the right to seek amendments to such infor-
25 mation, and the procedures for authorizing disclo-

1 sures of protected health information and for revok-
2 ing such authorizations.

3 “(2) PROCEDURES OF PROVIDER OR PLAN.—

4 The procedures established by the provider or plan
5 for the exercise of the rights of individuals about
6 whom protected health information is maintained.

7 “(3) AUTHORIZED DISCLOSURES.—The disclo-
8 sures of protected health information that are au-
9 thorized.

10 “(b) DISSEMINATION OF NOTICE.—A health care
11 provider or health plan—

12 “(1) shall, upon request, provide any individual
13 with a copy of the notice of information practices de-
14 scribed in subsection (a); and

15 “(2) shall make reasonable efforts to inform in-
16 dividuals in a clear and conspicuous manner of the
17 existence and availability of the notice.

18 “(c) MODEL NOTICE.—The Secretary, after notice
19 and opportunity for public comment, shall develop and dis-
20 seminate a model notice of information practices for use
21 by health care providers and health plans under this sec-
22 tion.

1 **“Subpart C—Standards for Electronic Disclosures**

2 **“SEC. 11882. STANDARDS FOR ELECTRONIC DISCLOSURES.**

3 “The Secretary shall promulgate standards for dis-
 4 closing protected health information in accordance with
 5 this subtitle in electronic form. Such standards shall in-
 6 clude standards relating to the creation, transmission, re-
 7 ceipt, and maintenance, of any written document required
 8 or authorized under this subtitle.

9 **“PART IV—SANCTIONS**

10 **“Subpart A—No Sanctions for Permissible Actions**

11 **“SEC. 11891. NO LIABILITY FOR PERMISSIBLE DISCLO-**
 12 **SURES.**

13 “A health information trustee who makes a disclosure
 14 of protected health information about an individual that
 15 is permitted by this subtitle shall not be liable to the indi-
 16 vidual for the disclosure under common law.

17 **“SEC. 11892. NO LIABILITY FOR INSTITUTIONAL REVIEW**
 18 **BOARD DETERMINATIONS.**

19 “If the members of an institutional review board
 20 make a determination in good faith that—

21 “(1) a health research project is of sufficient
 22 importance to outweigh the intrusion into the pri-
 23 vacy of an individual; and

24 “(2) the effectiveness of the project requires use
 25 of protected health information,

1 the members, the board, and the parent institution of the
2 board shall not be liable to the individual as a result of
3 the determination.

4 **“SEC. 11893. RELIANCE ON CERTIFIED ENTITY.**

5 “If a health information trustee contracts with a cer-
6 tified health information network service to make a disclo-
7 sure of any protected health information on behalf of such
8 trustee in accordance with this subtitle and such service
9 makes a disclosure of such information that is in violation
10 of this subtitle, the trustee shall not be liable for to the
11 individual who is the subject of the information for such
12 unlawful disclosure.

13 **“Subpart B—Civil Sanctions**

14 **“SEC. 11901. CIVIL PENALTY.**

15 “(a) VIOLATION.—Any health information trustee
16 who the Secretary determines has substantially failed to
17 comply with this subtitle shall be subject, in addition to
18 any other penalties that may be prescribed by law, to a
19 civil penalty of not more than \$10,000 for each such viola-
20 tion.

21 “(b) PROCEDURES FOR IMPOSITION OF PEN-
22 ALTIES.—Section 1128A, other than subsections (a) and
23 (b) and the second sentence of subsection (f) of that sec-
24 tion, shall apply to the imposition of a civil monetary pen-
25 alty under this section in the same manner as such provi-

1 sions apply with respect to the imposition of a penalty
2 under section 1128A.

3 **“SEC. 11902. CIVIL ACTION.**

4 “(a) IN GENERAL.—An individual who is aggrieved
5 by conduct in violation of this subtitle may bring a civil
6 action to recover—

7 “(1) the greater of actual damages or liquidated
8 damages of \$5,000;

9 “(2) punitive damages;

10 “(3) a reasonable attorney’s fee and expenses of
11 litigation;

12 “(4) costs of litigation; and

13 “(5) such preliminary and equitable relief as
14 the court determines to be appropriate.

15 “(b) LIMITATION.—No action may be commenced
16 under this section more than 3 years after the date on
17 which the violation was or should reasonably have been
18 discovered.

19 **“Subpart C—Criminal Sanctions**

20 **“SEC. 11911. WRONGFUL DISCLOSURE OF PROTECTED**
21 **HEALTH INFORMATION.**

22 “(a) OFFENSE.—A person who knowingly—

23 “(1) obtains protected health information relat-
24 ing to an individual in violation of this subtitle; or

1 “(2) discloses protected health information to
2 another person in violation of this subtitle,
3 shall be punished as provided in subsection (b).

4 “(b) PENALTIES.—A person described in subsection
5 (a) shall—

6 “(1) be fined not more than \$50,000, impris-
7 oned not more than 1 year, or both;

8 “(2) if the offense is committed under false pre-
9 tenses, be fined not more than \$100,000, imprisoned
10 not more than 5 years, or both; and

11 “(3) if the offense is committed with intent to
12 sell, transfer, or use protected health information for
13 commercial advantage, personal gain, or malicious
14 harm, fined not more than \$250,000, imprisoned not
15 more than 10 years, or both.

16 **“PART V—ADMINISTRATIVE PROVISIONS**

17 **“SEC. 11921. RELATIONSHIP TO OTHER LAWS.**

18 “(a) STATE LAW.—Except as provided in subsections
19 (b), (c), and (d), this subtitle preempts State law.

20 “(b) LAWS RELATING TO PUBLIC OR MENTAL
21 HEALTH.—Nothing in this subtitle shall be construed to
22 preempt or operate to the exclusion of any State law relat-
23 ing to public health or mental health that prevents or reg-
24 ulates disclosure of protected health information otherwise
25 allowed under this subtitle.

1 “(c) PRIVILEGES.—Nothing in this subtitle is in-
2 tended to preempt or modify State common or statutory
3 law to the extent such law concerns a privilege of a witness
4 or person in a court of the State. This subtitle does not
5 supersede or modify Federal common or statutory law to
6 the extent such law concerns a privilege of a witness or
7 person in a court of the United States. Authorizations
8 pursuant to section 11812 shall not be construed as a
9 waiver of any such privilege.

10 “(d) CERTAIN DUTIES UNDER STATE OR FEDERAL
11 LAW.—This subtitle shall not be construed to preempt,
12 supersede, or modify the operation of—

13 “(1) any law that provides for the reporting of
14 vital statistics such as birth or death information;

15 “(2) any law requiring the reporting of abuse or
16 neglect information about any individual;

17 “(3) subpart II of part E of title XXVI of the
18 Public Health Service Act (relating to notifications
19 of emergency response employees of possible expo-
20 sure to infectious diseases); or

21 “(4) any Federal law or regulation governing
22 confidentiality of alcohol and drug patient records.

23 **“SEC. 11922. RIGHTS OF INCOMPETENTS.**

24 “(a) EFFECT OF DECLARATION OF INCOM-
25 PETENCE.—Except as provided in section 11923, if an in-

1 individual has been declared to be incompetent by a court
2 of competent jurisdiction, the rights of the individual
3 under this subtitle shall be exercised and discharged in
4 the best interests of the individual through the individual's
5 representative.

6 “(b) NO COURT DECLARATION.—Except as provided
7 in section 11923, if a health care provider determines that
8 an individual, who has not been declared to be incom-
9 petent by a court of competent jurisdiction, suffers from
10 a medical condition that prevents the individual from act-
11 ing knowingly or effectively on the individual's own behalf,
12 the right of the individual to authorize disclosure may be
13 exercised and discharged in the best interest of the individ-
14 ual by the individual's representative.

15 **“SEC. 11923. EXERCISE OF RIGHTS.**

16 “(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPA-
17 BLE.—In the case of an individual—

18 “(1) who is 18 years of age or older, all rights
19 of the individual shall be exercised by the individual;
20 or

21 “(2) who, acting alone, has the legal right, as
22 determined by State law, to apply for and obtain a
23 type of medical examination, care, or treatment and
24 who has sought such examination, care, or treat-
25 ment, the individual shall exercise all rights of an in-

1 dividual under this subtitle with respect to protected
2 health information relating to such examination,
3 care, or treatment.

4 “(b) INDIVIDUALS UNDER 18.—Except as provided
5 in subsection (a)(2), in the case of an individual who is—

6 “(1) under 14 years of age, all the individual’s
7 rights under this subtitle shall be exercised through
8 the parent or legal guardian of the individual; or

9 “(2) 14, 15, 16, or 17 years of age, the rights
10 of inspection and amendment, and the right to au-
11 thorize disclosure of protected health information of
12 the individual may be exercised either by the individ-
13 ual or by the parent or legal guardian of the individ-
14 ual.”.

15 (b) CONFORMING AMENDMENT.—Title XI of the So-
16 cial Security Act (42 U.S.C. 1301 et seq.), as amended
17 by section 601, is amended by striking the title and insert-
18 ing the following:

1 **“TITLE XI—GENERAL PROVI-**
 2 **SIONS, PEER REVIEW, ADMIN-**
 3 **ISTRATIVE SIMPLIFICATION,**
 4 **AND PRIVACY”.**

5 **TITLE VII—ENHANCED PEN-**
 6 **ALTIES FOR HEALTH CARE**
 7 **FRAUD**

8 **Subtitle A—All-Payer Fraud and**
 9 **Abuse Control Program**

10 **SEC. 701. ALL-PAYER FRAUD AND ABUSE CONTROL PRO-**
 11 **GRAM.**

12 (a) ESTABLISHMENT OF PROGRAM.—

13 (1) IN GENERAL.—Not later than January 1,
 14 1995, the Secretary of Health and Human Services
 15 (in this title referred to as the “Secretary”), acting
 16 through the Office of the Inspector General of the
 17 Department of Health and Human Services, and the
 18 Attorney General shall establish a program—

19 (A) to coordinate Federal, State, and local
 20 law enforcement programs to control fraud and
 21 abuse with respect to the delivery of and pay-
 22 ment for health care in the United States,

23 (B) to conduct investigations, audits, eval-
 24 uations, and inspections relating to the delivery

1 of and payment for health care in the United
2 States,

3 (C) to facilitate the enforcement of the
4 provisions of sections 1128, 1128A, and 1128B
5 of the Social Security Act and other statutes
6 applicable to health care fraud and abuse, and

7 (D) to provide for the modification and es-
8 tablishment of safe harbors and to issue inter-
9 pretative rulings and special fraud alerts pursu-
10 ant to section 703.

11 (2) COORDINATION WITH HEALTH CARE
12 PLANS.—In carrying out the program established
13 under paragraph (1), the Secretary and the Attorney
14 General shall consult with, and arrange for the shar-
15 ing of data with representatives of health care plans.

16 (3) REGULATIONS.—

17 (A) IN GENERAL.—The Secretary and the
18 Attorney General shall by regulation establish
19 standards to carry out the program under para-
20 graph (1).

21 (B) INFORMATION STANDARDS.—

22 (i) IN GENERAL.—Such standards
23 shall include standards relating to the fur-
24 nishing of information by health care
25 plans, providers, and others to enable the

1 Secretary and the Attorney General to
2 carry out the program (including coordina-
3 tion with health care plans under para-
4 graph (2)).

5 (ii) CONFIDENTIALITY.—Such stand-
6 ards shall include procedures to assure
7 that such information is provided and uti-
8 lized in a manner that appropriately pro-
9 tects the confidentiality of the information
10 and the privacy of individuals receiving
11 health care services and items.

12 (iii) QUALIFIED IMMUNITY FOR PRO-
13 VIDING INFORMATION.—The provisions of
14 section 1157(a) of the Social Security Act
15 (relating to limitation on liability) shall
16 apply to a person providing information to
17 the Secretary or the Attorney General in
18 conjunction with their performance of du-
19 ties under this section, in the same manner
20 as such section applies to information pro-
21 vided to organizations with a contract
22 under part B of title XI of such Act, with
23 respect to the performance of such a con-
24 tract.

1 (C) DISCLOSURE OF OWNERSHIP INFOR-
2 MATION.—

3 (i) IN GENERAL.—Such standards
4 shall include standards relating to the dis-
5 closure of ownership information described
6 in clause (ii) by any entity providing health
7 care services and items.

8 (ii) OWNERSHIP INFORMATION DE-
9 SCRIBED.—The ownership information de-
10 scribed in this clause includes—

11 (I) a description of such items
12 and services provided by such entity;

13 (II) the names and unique physi-
14 cian identification numbers of all phy-
15 sicians with a financial relationship
16 (as defined in section 1877(a)(2) of
17 the Social Security Act) with such en-
18 tity;

19 (III) the names of all other indi-
20 viduals with such an ownership or in-
21 vestment interest in such entity; and

22 (IV) any other ownership and re-
23 lated information required to be dis-
24 closed by such entity under section

1 1124 or section 1124A of the Social
2 Security Act.

3 (4) AUTHORIZATION OF APPROPRIATIONS FOR
4 INVESTIGATORS AND OTHER PERSONNEL.—In addi-
5 tion to any other amounts authorized to be appro-
6 priated to the Secretary and the Attorney General
7 for health care anti-fraud and abuse activities for a
8 fiscal year, there are authorized to be appropriated
9 additional amounts as may be necessary to enable
10 the Secretary and the Attorney General to conduct
11 investigations and audits of allegations of health
12 care fraud and abuse and otherwise carry out the
13 program established under paragraph (1) in a fiscal
14 year.

15 (5) ENSURING ACCESS TO DOCUMENTATION.—
16 The Inspector General of the Department of Health
17 and Human Services is authorized to exercise the
18 authority described in paragraphs (4) and (5) of sec-
19 tion 6 of the Inspector General Act of 1978 (relating
20 to subpoenas and administration of oaths) with re-
21 spect to the activities under the all-payer fraud and
22 abuse control program established under this sub-
23 section to the same extent as such Inspector General
24 may exercise such authorities to perform the func-
25 tions assigned by such Act.

1 (6) HEALTH CARE PLAN DEFINED.—For the
2 purposes of this subsection, the term “health care
3 plan” shall have the meaning given such term in sec-
4 tion 1128(i) of the Social Security Act.

5 (b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE
6 TRUST FUND.—

7 (1) ESTABLISHMENT.—

8 (A) IN GENERAL.—There is hereby created
9 on the books of the Treasury of the United
10 States a trust fund to be known as the “Anti-
11 Fraud and Abuse Trust Fund” (in this section
12 referred to as the “Trust Fund”). The Trust
13 Fund shall consist of such gifts and bequests as
14 may be made as provided in subparagraph (B)
15 and such amounts as may be deposited in, or
16 appropriated to, such Trust Fund as provided
17 in subsection (a)(4), sections 731(b), 732(b),
18 and 741(b) of this Act, and title XI of the So-
19 cial Security Act.

20 (B) AUTHORIZATION TO ACCEPT GIFTS.—
21 The Managing Trustee of the Trust Fund is
22 authorized to accept on behalf of the United
23 States money gifts and bequests made uncondi-
24 tionally to the Trust Fund, for the benefit of

1 the Trust Fund, or any activity financed
2 through the Trust Fund.

3 (2) MANAGEMENT.—

4 (A) IN GENERAL.—The Trust Fund shall
5 be managed by the Secretary and the Attorney
6 General through a Managing Trustee des-
7 ignated by the Secretary and the Attorney Gen-
8 eral.

9 (B) INVESTMENT OF FUNDS.—

10 (i) IN GENERAL.—It shall be the duty
11 of the Managing Trustee to invest such
12 portion of the Trust Fund as is not, in the
13 Managing Trustee's judgment, required to
14 meet current withdrawals.

15 (ii) GENERAL FORM OF INVEST-
16 MENT.—Investments described in clause (i)
17 may be made only in interest-bearing obli-
18 gations of the United States or in obliga-
19 tions guaranteed as to both principal and
20 interest by the United States. For such
21 purpose such obligations may be ac-
22 quired—

23 (I) on original issue at the issue
24 price, or

1 (II) by purchase of outstanding
2 obligations at market price.

3 (iii) ISSUANCE OF PUBLIC-DEBT OBLI-
4 GATIONS.—The purposes for which obliga-
5 tions of the United States may be issued
6 under chapter 31 of title 31, United States
7 Code, are hereby extended to authorize the
8 issuance at par of public-debt obligations
9 for purchase by the Trust Fund. Such obli-
10 gations issued for purchase by the Trust
11 Fund shall have maturities fixed with due
12 regard for the needs of the Trust Fund
13 and shall bear interest at a rate equal to
14 the average market yield (computed by the
15 Managing Trustee on the basis of market
16 quotations as of the end of the calendar
17 month next preceding the date of such
18 issue) on all marketable interest-bearing
19 obligations of the United States then form-
20 ing a part of the public debt which are not
21 due or callable until after the expiration of
22 4 years from the end of such calendar
23 month, except that where such average is
24 not a multiple of $\frac{1}{8}$ of 1 percent, the rate
25 of interest on such obligations shall be the

multiple of $\frac{1}{8}$ of 1 percent nearest such market yield.

(iv) PURCHASES OF OTHER OBLIGATIONS.—The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Managing Trustee determines that the purchase of such other obligations is in the public interest.

(C) SALE OF OBLIGATIONS.—Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(D) INTEREST ON OBLIGATIONS AND PROCEEDS FROM SALE OR REDEMPTION OF OBLIGATIONS.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

1 (E) RECEIPTS AND DISBURSEMENTS NOT
2 INCLUDED IN UNITED STATES GOVERNMENT
3 BUDGET TOTALS.—The receipts and disburse-
4 ments of the Secretary and the Attorney Gen-
5 eral in the discharge of the functions of the
6 Secretary and the Attorney General under the
7 all-payer fraud and abuse control program es-
8 tablished under subsection (a) shall not be in-
9 cluded in the totals of the budget of the United
10 States Government. For purposes of part C of
11 the Balanced Budget and Emergency Deficit
12 Control Act of 1985, the Secretary, the Attor-
13 ney General, and the Trust Fund shall be treat-
14 ed in the same manner as the Federal Retire-
15 ment Thrift Investment Board and the Thrift
16 Savings Fund, respectively. The United States
17 is not liable for any obligation or liability in-
18 curred by the Trust Fund.

19 (3) USE OF FUNDS.—

20 (A) IN GENERAL.—Amounts in the Trust
21 Fund shall be used without regard to fiscal year
22 limitation to assist the Inspector General of the
23 Department of Health and Human Services and
24 the Attorney General in carrying out the all-

1 payer fraud and abuse control program estab-
2 lished under subsection (a).

3 (B) OVERALL ADMINISTRATION.—The
4 Managing Trustee shall also pay from time to
5 time from the Trust Fund such amounts as the
6 Secretary and the Attorney General certify are
7 necessary to carry out the all-payer fraud and
8 abuse control program established under sub-
9 section (a).

10 (4) ANNUAL REPORT.—The Managing Trustee
11 shall be required to submit an annual report to Con-
12 gress on the amount of revenue which is generated
13 and disbursed by the Trust Fund in each fiscal year.
14 Such report shall include an estimate of the amount
15 of additional appropriations authorized under sub-
16 section (a)(4) necessary for the Secretary and the
17 Attorney General to conduct the all-payer fraud and
18 abuse program established under subsection (a) in
19 the next fiscal year.

20 **SEC. 702. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD**
21 **AND ABUSE SANCTIONS TO ALL FRAUD AND**
22 **ABUSE AGAINST ANY HEALTH CARE PLAN.**

23 (a) CIVIL MONETARY PENALTIES.—Section 1128A
24 of the Social Security Act (42 U.S.C. 1320a–7a) is amend-
25 ed as follows:

1 (1) In subsection (a)(1), by inserting “or of any
2 health care plan (as defined in section 1128(i)),”
3 after “subsection (i)(1)),”.

4 (2) In subsection (b)(1)(A), by inserting “or
5 under a health care plan” after “title XIX”.

6 (3) In subsection (f)—

7 (A) by redesignating paragraph (3) as
8 paragraph (4); and

9 (B) by inserting after paragraph (2) the
10 following new paragraphs:

11 “(3) With respect to amounts recovered arising
12 out of a claim under a health care plan, the portion
13 of such amounts as is determined to have been paid
14 by the plan shall be repaid to the plan, and the por-
15 tion of such amounts attributable to the amounts re-
16 covered under this section by reason of the amend-
17 ments made by title VII of the America’s Health
18 Care Option Act (as estimated by the Secretary)
19 shall be deposited into the Anti-Fraud and Abuse
20 Trust Fund established under section 701(b) of such
21 Act.”.

22 (4) In subsection (i)—

23 (A) in paragraph (2), by inserting “or
24 under a health care plan” before the period at
25 the end, and

1 (B) in paragraph (5), by inserting “or
2 under a health care plan” after “or XX”.

3 (b) CRIMES.—

4 (1) SOCIAL SECURITY ACT.—Section 1128B of
5 such Act (42 U.S.C. 1320a–7b) is amended as fol-
6 lows:

7 (A) In the heading, by adding at the end
8 the following: “OR HEALTH CARE PLANS”.

9 (B) In subsection (a)(1)—

10 (i) by striking “title XVIII or” and
11 inserting “title XVIII,” and

12 (ii) by adding at the end the follow-
13 ing: “or a health care plan (as defined in
14 section 1128(i)),”.

15 (C) In subsection (a)(5), by striking “title
16 XVIII or a State health care program” and in-
17 serting “title XVIII, a State health care pro-
18 gram, or a health care plan”.

19 (D) In the second sentence of subsection
20 (a)—

21 (i) by inserting after “title XIX” the
22 following: “or a health care plan”, and

23 (ii) by inserting after “the State” the
24 following: “or the plan”.

1 (E) In subsection (b)(1), by striking “title
2 XVIII or a State health care program” each
3 place it appears and inserting “title XVIII, a
4 State health care program, or a health care
5 plan”.

6 (F) In subsection (b)(2), by striking “title
7 XVIII or a State health care program” each
8 place it appears and inserting “title XVIII, a
9 State health care program, or a health care
10 plan”.

11 (G) In subsection (b)(3), by striking “title
12 XVIII or a State health care program” each
13 place it appears in subparagraphs (A) and (C)
14 and inserting “title XVIII, a State health care
15 program, or a health care plan”.

16 (H) In subsection (d)(2)—

17 (i) by striking “title XIX,” and insert-
18 ing “title XIX or under a health care
19 plan,” and

20 (ii) by striking “State plan,” and in-
21 serting “State plan or the health care
22 plan,”.

23 (2) IDENTIFICATION OF COMMUNITY SERVICE
24 OPPORTUNITIES.—Section 1128B of such Act (42

1 U.S.C. 1320a–7b) is further amended by adding at
2 the end the following new subsection:

3 “(f) The Secretary may—

4 “(1) in consultation with State and local health
5 care officials, identify opportunities for the satisfac-
6 tion of community service obligations that a court
7 may impose upon the conviction of an offense under
8 this section, and

9 “(2) make information concerning such oppor-
10 tunities available to Federal and State law enforce-
11 ment officers and State and local health care
12 officials.”.

13 (c) HEALTH CARE PLAN DEFINED.—Section 1128 of
14 such Act (42 U.S.C. 1320a–7) is amended by redesignat-
15 ing subsection (i) as subsection (j) and by inserting after
16 subsection (h) the following new subsection:

17 “(i) HEALTH CARE PLAN DEFINED.—For purposes
18 of sections 1128A and 1128B, the term ‘health care plan’
19 means a public or private program for the delivery of or
20 payment for health care items or services other than the
21 medicare program, the medicaid program, or a State
22 health care program.”.

23 (d) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect on January 1, 1995.

1 **SEC. 703. HEALTH CARE FRAUD AND ABUSE GUIDANCE.**

2 (a) SOLICITATION AND PUBLICATION OF MODIFICA-
3 TIONS TO EXISTING SAFE HARBORS AND NEW SAFE
4 HARBORS.—

5 (1) IN GENERAL.—

6 (A) SOLICITATION OF PROPOSALS FOR
7 SAFE HARBORS.—Not later than January 1,
8 1995, and not less than annually thereafter, the
9 Secretary shall publish a notice in the Federal
10 Register soliciting proposals, which will be ac-
11 cepted during a 60-day period, for—

12 (i) modifications to existing safe har-
13 bors issued pursuant to section 14(a) of
14 the Medicare and Medicaid Patient and
15 Program Protection Act of 1987 (42
16 U.S.C. 1320a–7b note);

17 (ii) additional safe harbors specifying
18 payment practices that shall not be treated
19 as a criminal offense under section
20 1128B(b) of the Social Security Act the
21 (42 U.S.C. 1320a–7b(b)) and shall not
22 serve as the basis for an exclusion under
23 section 1128(b)(7) of such Act (42 U.S.C.
24 1320a–7(b)(7));

25 (iii) interpretive rulings to be issued
26 pursuant to subsection (b); and

1 (iv) special fraud alerts to be issued
2 pursuant to subsection (c).

3 (B) PUBLICATION OF PROPOSED MODI-
4 FICATIONS AND PROPOSED ADDITIONAL STATE
5 HARBORS.—After considering the proposals de-
6 scribed in clauses (i) and (ii) of subparagraph
7 (A), the Secretary, in consultation with the At-
8 torney General, shall publish in the Federal
9 Register proposed modifications to existing safe
10 harbors and proposed additional safe harbors, if
11 appropriate, with a 60-day comment period.
12 After considering any public comments received
13 during this period, the Secretary shall issue
14 final rules modifying the existing safe harbors
15 and establishing new safe harbors, as appro-
16 priate.

17 (C) REPORT.—The Inspector General of
18 the Department of Health and Human Services
19 (hereafter in this section referred to as the “In-
20 spector General”) shall, in an annual report to
21 Congress or as part of the year-end semiannual
22 report required by section 5 of the Inspector
23 General Act of 1978 (5 U.S.C. App.), describe
24 the proposals received under clauses (i) and (ii)
25 of subparagraph (A) and explain which propos-

1 als were included in the publication described in
2 subparagraph (B), which proposals were not in-
3 cluded in that publication, and the reasons for
4 the rejection of the proposals that were not in-
5 cluded.

6 (2) CRITERIA FOR MODIFYING AND ESTABLISH-
7 ING SAFE HARBORS.—In modifying and establishing
8 safe harbors under paragraph (1)(B), the Secretary
9 may consider the extent to which providing a safe
10 harbor for the specified payment practice may result
11 in any of the following:

12 (A) An increase or decrease in access to
13 health care services.

14 (B) An increase or decrease in the quality
15 of health care services.

16 (C) An increase or decrease in patient free-
17 dom of choice among health care providers.

18 (D) An increase or decrease in competition
19 among health care providers.

20 (E) An increase or decrease in the ability
21 of health care facilities to provide services in
22 medically underserved areas or to medically un-
23 derserved populations.

24 (F) An increase or decrease in the cost to
25 Government health care programs.

1 (G) An increase or decrease in the poten-
2 tial overutilization of health care services.

3 (H) The existence or nonexistence of any
4 potential financial benefit to a health care pro-
5 fessional or provider which may vary based on
6 their decisions of—

7 (i) whether to order a health care
8 item or service; or

9 (ii) whether to arrange for a referral
10 of health care items or services to a par-
11 ticular practitioner or provider.

12 (I) Any other factors the Secretary deems
13 appropriate in the interest of preventing fraud
14 and abuse in Government health care programs.

15 (b) INTERPRETIVE RULINGS.—

16 (1) IN GENERAL.—

17 (A) REQUEST FOR INTERPRETIVE RUL-
18 ING.—Any person may present, at any time, a
19 request to the Inspector General for a state-
20 ment of the Inspector General’s current inter-
21 pretation of the meaning of a specific aspect of
22 the application of sections 1128A and 1128B of
23 the Social Security Act (hereafter in this sec-
24 tion referred to as an “interpretive ruling”).

1 (B) ISSUANCE AND EFFECT OF INTERPRE-
2 TIVE RULING.—

3 (i) IN GENERAL.—If appropriate, the
4 Inspector General shall in consultation
5 with the Attorney General, issue an inter-
6 pretive ruling in response to a request de-
7 scribed in subparagraph (A). Interpretive
8 rulings shall not have the force of law and
9 shall be treated as an interpretive rule
10 within the meaning of section 553(b) of
11 title 5, United States Code. All interpretive
12 rulings issued pursuant to this provision
13 shall be published in the Federal Register
14 or otherwise made available for public in-
15 spection.

16 (ii) REASONS FOR DENIAL.—If the In-
17 spector General does not issue an interpre-
18 tive ruling in response to a request de-
19 scribed in subparagraph (A), the Inspector
20 General shall notify the requesting party of
21 such decision and shall identify the reasons
22 for such decision.

23 (2) CRITERIA FOR INTERPRETIVE RULINGS.—

1 (A) IN GENERAL.—In determining whether
2 to issue an interpretive ruling under paragraph
3 (1)(B), the Inspector General may consider—

4 (i) whether and to what extent the re-
5 quest identifies an ambiguity within the
6 language of the statute, the existing safe
7 harbors, or previous interpretive rulings;
8 and

9 (ii) whether the subject of the re-
10 quested interpretive ruling can be ade-
11 quately addressed by interpretation of the
12 language of the statute, the existing safe
13 harbor rules, or previous interpretive rul-
14 ings, or whether the request would require
15 a substantive ruling not authorized under
16 this subsection.

17 (B) NO RULINGS ON FACTUAL ISSUES.—

18 The Inspector General shall not give an inter-
19 pretive ruling on any factual issue, including
20 the intent of the parties or the fair market
21 value of particular leased space or equipment.

22 (c) SPECIAL FRAUD ALERTS.—

23 (1) IN GENERAL.—

24 (A) REQUEST FOR SPECIAL FRAUD
25 ALERTS.—Any person may present, at any

1 time, a request to the Inspector General for a
2 notice which informs the public of practices
3 which the Inspector General considers to be
4 suspect or of particular concern under section
5 1128B(b) of the Social Security Act (42 U.S.C.
6 1320a-7b(b)) (hereafter in this subsection re-
7 ferred to as a “special fraud alert”).

8 (B) ISSUANCE AND PUBLICATION OF SPE-
9 CIAL FRAUD ALERTS.—Upon receipt of a re-
10 quest described in subparagraph (A), the In-
11 spector General shall investigate the subject
12 matter of the request to determine whether a
13 special fraud alert should be issued. If appro-
14 priate, the Inspector General shall in consulta-
15 tion with the Attorney General, issue a special
16 fraud alert in response to the request. All spe-
17 cial fraud alerts issued pursuant to this sub-
18 paragraph shall be published in the Federal
19 Register.

20 (2) CRITERIA FOR SPECIAL FRAUD ALERTS.—
21 In determining whether to issue a special fraud alert
22 upon a request described in paragraph (1), the In-
23 spector General may consider—

24 (A) whether and to what extent the prac-
25 tices that would be identified in the special

1 fraud alert may result in any of the con-
2 sequences described in subsection (a)(2); and

3 (B) the volume and frequency of the con-
4 duct that would be identified in the special
5 fraud alert.

6 **SEC. 704. REPORTING OF FRAUDULENT ACTIONS UNDER**
7 **MEDICARE.**

8 Not later than 1 year after the date of the enactment
9 of this Act, the Secretary shall establish a program
10 through which individuals entitled to benefits under the
11 medicare program may report to the Secretary on a con-
12 fidential basis (at the individual's request) instances of
13 suspected fraudulent actions arising under the program by
14 providers of items and services under the program.

15 **Subtitle B—Revisions to Current**
16 **Sanctions for Fraud and Abuse**

17 **SEC. 711. MANDATORY EXCLUSION FROM PARTICIPATION**
18 **IN MEDICARE AND STATE HEALTH CARE PRO-**
19 **GRAMS.**

20 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
21 TO FRAUD.—

22 (1) IN GENERAL.—Section 1128(a) of the
23 Social Security Act (42 U.S.C. 1320a–7(a)) is
24 amended by adding at the end the following new
25 paragraph:

1 “(3) FELONY CONVICTION RELATING TO
 2 FRAUD.—Any individual or entity that has been con-
 3 victed, under Federal or State law, in connection
 4 with the delivery of a health care item or service or
 5 with respect to any act or omission in a program
 6 (other than those specifically described in paragraph
 7 (1)) operated by or financed in whole or in part by
 8 any Federal, State, or local government agency, of
 9 a criminal offense consisting of a felony relating to
 10 fraud, theft, embezzlement, breach of fiduciary re-
 11 sponsibility, or other financial misconduct.”.

12 (2) CONFORMING AMENDMENT.—Section
 13 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1))
 14 is amended—

15 (A) in the heading, by striking “CONVIC-
 16 TION” and inserting “MISDEMEANOR CONVIC-
 17 TION”; and

18 (B) by striking “criminal offense” and in-
 19 serting “criminal offense consisting of a mis-
 20 demeanor”.

21 (b) INDIVIDUAL CONVICTED OF FELONY RELATING
 22 TO CONTROLLED SUBSTANCE.—

23 (1) IN GENERAL.—Section 1128(a) of the So-
 24 cial Security Act (42 U.S.C. 1320a–7(a)), as amend-

1 ed by subsection (a), is amended by adding at the
 2 end the following new paragraph:

3 “(4) FELONY CONVICTION RELATING TO CON-
 4 TROLLED SUBSTANCE.—Any individual or entity
 5 that has been convicted, under Federal or State law,
 6 of a criminal offense consisting of a felony relating
 7 to the unlawful manufacture, distribution, prescrip-
 8 tion, or dispensing of a controlled substance.”.

9 (2) CONFORMING AMENDMENT.—Section
 10 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3))
 11 is amended—

12 (A) in the heading, by striking “CONVIC-
 13 TION” and inserting “MISDEMEANOR CONVIC-
 14 TION”; and

15 (B) by striking “criminal offense” and in-
 16 serting “criminal offense consisting of a mis-
 17 demeanor”.

18 **SEC. 712. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
 19 **CLUSION FOR CERTAIN INDIVIDUALS AND**
 20 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
 21 **SION FROM MEDICARE AND STATE HEALTH**
 22 **CARE PROGRAMS.**

23 Section 1128(c)(3) of the Social Security Act (42
 24 U.S.C. 1320a–7(c)(3)) is amended by adding at the end
 25 the following new subparagraphs:

1 “(D) In the case of an exclusion of an individual or
 2 entity under paragraph (1), (2), or (3) of subsection (b),
 3 the period of the exclusion shall be 3 years, unless the
 4 Secretary determines in accordance with published regula-
 5 tions that a shorter period is appropriate because of miti-
 6 gating circumstances or that a longer period is appro-
 7 priate because of aggravating circumstances.

8 “(E) In the case of an exclusion of an individual or
 9 entity under subsection (b)(4) or (b)(5), the period of the
 10 exclusion shall not be less than the period during which
 11 the individual’s or entity’s license to provide health care
 12 is revoked, suspended, or surrendered, or the individual
 13 or the entity is excluded or suspended from a Federal or
 14 State health care program.

15 “(F) In the case of an exclusion of an individual or
 16 entity under subsection (b)(6)(B), the period of the exclu-
 17 sion shall be not less than 1 year.”.

18 **SEC. 713. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
 19 **OWNERSHIP OR CONTROL INTEREST IN**
 20 **SANCTIONED ENTITIES.**

21 Section 1128(b) of the Social Security Act (42 U.S.C.
 22 1320a–7(b)) is amended by adding at the end the follow-
 23 ing new paragraph:

24 “(15) INDIVIDUALS CONTROLLING A SANC-
 25 TIONED ENTITY.—Any individual who has a direct

1 or indirect ownership or control interest of 5 percent
 2 or more, or an ownership or control interest (as de-
 3 fined in section 1124(a)(3)) in, or who is an officer,
 4 director, agent, or managing employee (as defined in
 5 section 1126(b)) of, an entity—

6 “(A) that has been convicted of any of-
 7 fense described in subsection (a) or in para-
 8 graph (1), (2), or (3) of this subsection;

9 “(B) against which a civil monetary pen-
 10 alty has been assessed under section 1128A; or

11 “(C) that has been excluded from partici-
 12 pation under a program under title XVIII or
 13 under a State health care program.”.

14 **SEC. 714. CIVIL MONETARY PENALTIES.**

15 (a) PROHIBITION AGAINST OFFERING INDUCEMENTS
 16 TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY
 17 PROGRAMS OR PLANS.—

18 (1) INDUCEMENTS TO INDIVIDUALS ENROLLED
 19 UNDER MEDICARE.—

20 (A) OFFER OF REMUNERATION.—Section
 21 1128A(a) of the Social Security Act (42 U.S.C.
 22 1320a–7a(a)) is amended—

23 (i) by striking “or” at the end of
 24 paragraph (1)(D);

1 (ii) by striking “, or” at the end of
2 paragraph (2) and inserting a semicolon;

3 (iii) by striking the semicolon at the
4 end of paragraph (3) and inserting “; or”;
5 and

6 (iv) by inserting after paragraph (3)
7 the following new paragraph:

8 “(4) offers to or transfers remuneration to any
9 individual eligible for benefits under title XVIII of
10 this Act, or under a State health care program (as
11 defined in section 1128(h)) that such person knows
12 or should know is likely to influence such individual
13 to order or receive from a particular provider, practi-
14 tioner, or supplier any item or service for which pay-
15 ment may be made, in whole or in part, under title
16 XVIII, or a State health care program;”.

17 (B) REMUNERATION DEFINED.—Section
18 1128A(i) is amended by adding the following
19 new paragraph:

20 “(6) The term ‘remuneration’ includes the waiv-
21 er of coinsurance and deductible amounts (or any
22 part thereof), and transfers of items or services for
23 free or for other than fair market value. The term
24 ‘remuneration’ does not include the waiver of coin-
25 surance and deductible amounts by a person, if—

1 “(A) the waiver is not offered as part of
2 any advertisement or solicitation;

3 “(B) the person does not routinely waive
4 coinsurance or deductible amounts; and

5 “(C) the person—

6 “(i) waives the coinsurance and de-
7 ductible amounts after determining in good
8 faith that the individual is in financial
9 need;

10 “(ii) fails to collect coinsurance or de-
11 ductible amounts after making reasonable
12 collection efforts; or

13 “(iii) provides for any permissible
14 waiver as specified in section 1128B(b)(3)
15 or in regulations issued by the Secretary.”.

16 (2) INDUCEMENTS TO EMPLOYEES.—Section
17 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as
18 amended by paragraph (1), is further amended—

19 (A) by striking “or” at the end of para-
20 graph (3);

21 (B) by striking the semicolon at the end of
22 paragraph (4) and inserting “; or”; and

23 (C) by inserting after paragraph (4) the
24 following new paragraph:

1 “(5) pays a bonus, reward, or any other remuneration, directly or indirectly, to an employee to induce the employee to encourage individuals to seek or obtain covered items or services for which payment may be made under the medicare program, or a State health care program where the amount of the remuneration is determined in a manner that takes into account (directly or indirectly) the value or volume of any referrals by the employee to the employer for covered items or services;”.

11 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
12 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—
13 Section 1128A(a) of such Act, as amended by subsection
14 (a), is further amended—

15 (1) by striking “or” at the end of paragraph
16 (4);

17 (2) by striking the semicolon at the end of
18 paragraph (5) and inserting “; or”; and

19 (3) by inserting after paragraph (5) the following new paragraph:

21 “(6) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the

1 time of a violation of this subsection, retains a direct
 2 or indirect ownership or control interest of 5 percent
 3 or more, or an ownership or control interest (as de-
 4 fined in section 1124(a)(3)) in, or who is an officer,
 5 director, agent, or managing employee (as defined in
 6 section 1126(b)) of, an entity that is participating in
 7 a program under title XVIII or a State health care
 8 program;”.

9 (c) MISUSE OF HEALTH SECURITY CARD OR UNIQUE
 10 HEALTH IDENTIFIER.—Section 1128A(a) of such Act, as
 11 amended by subsection (b), is further amended—

12 (1) by striking “or” at the end of paragraph
 13 (5);

14 (2) by striking the semicolon at the end of
 15 paragraph (6) and inserting “; or”; and

16 (3) by inserting after paragraph (6) the follow-
 17 ing new paragraphs:

18 “(7) requires the display of, requires the use of,
 19 or uses a health security card that is issued under
 20 subtitle B of this title for any purpose other than a
 21 purpose described in such subtitle;

22 “(8) requires the disclosure of, requires the use
 23 of, or uses an individual’s unique health identifier
 24 established under subtitle B of this title for any pur-
 25 pose that is not authorized by the Secretary;”.

1 (d) MODIFICATIONS OF AMOUNTS OF PENALTIES
2 AND ASSESSMENTS.—Section 1128A(a) of such Act (42
3 U.S.C. 1320a–7a(a)), as amended by subsections (a) and
4 (b), is amended in the matter following paragraph (6)—

5 (1) by striking “\$2,000” and inserting
6 “\$10,000”;

7 (2) by inserting “; in cases under paragraph
8 (4), \$10,000 for each such offer or transfer; in cases
9 under paragraph (5), \$10,000 for each such pay-
10 ment; in cases under paragraph (6), \$10,000 for
11 each day the prohibited relationship occurs; in cases
12 under paragraph (7) or (8), \$10,000 per violation”
13 after “false or misleading information was given”;

14 (3) by striking “twice the amount” and insert-
15 ing “3 times the amount”; and

16 (4) by inserting “(or, in cases under paragraphs
17 (4) and (5), 3 times the amount of the illegal remu-
18 neration)” after “for each such item or service”.

19 (e) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
20 RECT CODING OR MEDICALLY UNNECESSARY SERV-
21 ICES.—Section 1128A(a)(1) of such Act (42 U.S.C.
22 1320a–7a(a)(1)) is amended—

23 (1) in subparagraph (A) by striking “claimed,”
24 and inserting the following: “claimed, including any
25 person who presents or causes to be presented a

1 claim for an item or service that is based on a code
2 that the person knows or should know will result in
3 a greater payment to the person than the code the
4 person knows or should know is applicable to the
5 item or service actually provided,”;

6 (2) in subparagraph (C), by striking “or” at
7 the end;

8 (3) in subparagraph (D), by striking “; or” and
9 inserting “, or”; and

10 (4) by inserting after subparagraph (D) the fol-
11 lowing new subparagraph:

12 “(E) is for a medical or other item or serv-
13 ice that a person knows or should know is not
14 medically necessary; or”.

15 **SEC. 715. ACTIONS SUBJECT TO CRIMINAL PENALTIES.**

16 (a) PERMITTING SECRETARY TO IMPOSE CIVIL MON-
17 ETARY PENALTY.—Section 1128A(b) of the Social Secu-
18 rity Act (42 U.S.C. 1320a–7a(a)) is amended by adding
19 the following new paragraph:

20 “(3) Any person (including any organization,
21 agency, or other entity, but excluding a beneficiary
22 as defined in subsection (i)(5)) who the Secretary
23 determines has violated section 1128B(b) of this
24 title shall be subject to a civil monetary penalty of
25 not more than \$10,000 for each such violation. In

1 addition, such person shall be subject to an assess-
2 ment of not more than twice the total amount of the
3 remuneration offered, paid, solicited, or received in
4 violation of section 1128B(b). The total amount of
5 remuneration subject to an assessment shall be cal-
6 culated without regard to whether some portion
7 thereof also may have been intended to serve a pur-
8 pose other than one proscribed by section
9 1128B(b).”.

10 (b) RESTRICTION ON APPLICATION OF EXCEPTION
11 FOR AMOUNTS PAID TO EMPLOYEES.—Section
12 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a-
13 7b(b)(3)(B)) is amended by striking “services;” and in-
14 serting the following: “services, but only if the amount of
15 remuneration under the arrangement is (i) consistent with
16 fair market value; (ii) not determined in a manner that
17 takes into account (directly or indirectly) the volume or
18 value of any referrals by the employee to the employer for
19 the furnishing (or arranging for the furnishing) of such
20 items or services; and (iii) provided pursuant to an ar-
21 rangement that would be commercially reasonable even if
22 no referrals were made;”.

1 **SEC. 716. SANCTIONS AGAINST PRACTITIONERS AND PER-**
2 **SONS FOR FAILURE TO COMPLY WITH STATU-**
3 **TORY OBLIGATIONS.**

4 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
5 TIONERS AND PERSONS FAILING TO MEET STATUTORY
6 OBLIGATIONS.—

7 (1) IN GENERAL.—The second sentence of sec-
8 tion 1156(b)(1) of the Social Security Act (42
9 U.S.C. 1320c-5(b)(1)) is amended by striking “may
10 prescribe)” and inserting “may prescribe, except
11 that such period may not be less than 1 year)”.

12 (2) CONFORMING AMENDMENT.—Section
13 1156(b)(2) of such Act (42 U.S.C. 1320c-5(b)(2)) is
14 amended by striking “shall remain” and inserting
15 “shall (subject to the minimum period specified in
16 the second sentence of paragraph (1)) remain”.

17 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
18 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
19 of such Act (42 U.S.C. 1320c-5(b)(1)) is amended—

20 (1) in the second sentence, by striking “and de-
21 termines” and all that follows through “such obliga-
22 tions,”; and

23 (2) by striking the third sentence.

24 (c) AMOUNT OF CIVIL MONEY PENALTY.—Section
25 1156(b)(3) of such Act (42 U.S.C. 1320c-5(b)(3)) is

1 amended by striking “the actual or estimated cost” and
2 inserting the following: “up to \$10,000 for each instance”.

3 **SEC. 717. INTERMEDIATE SANCTIONS FOR MEDICARE**
4 **HEALTH MAINTENANCE ORGANIZATIONS.**

5 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
6 ANY PROGRAM VIOLATIONS.—

7 (1) IN GENERAL.—Section 1876(i)(1) of the
8 Social Security Act (42 U.S.C. 1395mm(i)(1)) is
9 amended by striking “the Secretary may terminate”
10 and all that follows and inserting the following: “in
11 accordance with procedures established under para-
12 graph (9), the Secretary may at any time terminate
13 any such contract or may impose the intermediate
14 sanctions described in paragraph (6)(B) or (6)(C)
15 (whichever is applicable) on the eligible organization
16 if the Secretary determines that the organization—

17 “(A) has failed substantially to carry out
18 the contract;

19 “(B) is carrying out the contract in a man-
20 ner inconsistent with the efficient and effective
21 administration of this section;

22 “(C) is operating in a manner that is not
23 in the best interests of the individuals covered
24 under the contract; or

1 “(D) no longer substantially meets the ap-
2 plicable conditions of subsections (b), (c), (e),
3 and (f).”.

4 (2) OTHER INTERMEDIATE SANCTIONS FOR
5 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
6 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is
7 amended by adding at the end the following new
8 subparagraph:

9 “(C) In the case of an eligible organization for which
10 the Secretary makes a determination under paragraph (1)
11 the basis of which is not described in subparagraph (A),
12 the Secretary may apply the following intermediate sanc-
13 tions:

14 “(i) Civil money penalties of not more than
15 \$25,000 for each determination under paragraph (1)
16 if the deficiency that is the basis of the determina-
17 tion has directly adversely affected (or has the sub-
18 stantial likelihood of adversely affecting) an individ-
19 ual covered under the organization’s contract.

20 “(ii) Civil money penalties of not more than
21 \$10,000 for each week beginning after the initiation
22 of procedures by the Secretary under paragraph (9)
23 during which the deficiency that is the basis of a de-
24 termination under paragraph (1) exists.

1 “(iii) Suspension of enrollment of individuals
2 under this section after the date the Secretary noti-
3 fies the organization of a determination under para-
4 graph (1) and until the Secretary is satisfied that
5 the deficiency that is the basis for the determination
6 has been corrected and is not likely to recur.”.

7 (3) PROCEDURES FOR IMPOSING SANCTIONS.—
8 Section 1876(i) of such Act (42 U.S.C. 1395mm(i))
9 is amended by adding at the end the following new
10 paragraph:

11 “(9) The Secretary may terminate a contract with an
12 eligible organization under this section or may impose the
13 intermediate sanctions described in paragraph (6) on the
14 organization in accordance with formal investigation and
15 compliance procedures established by the Secretary under
16 which—

17 “(A) the Secretary provides the organization
18 with the opportunity to develop and implement a
19 corrective action plan to correct the deficiencies that
20 were the basis of the Secretary’s determination
21 under paragraph (1);

22 “(B) in deciding whether to impose sanctions,
23 the Secretary considers aggravating factors such as
24 whether an entity has a history of deficiencies or has

1 not taken action to correct deficiencies the Secretary
2 has brought to their attention;

3 “(C) there are no unreasonable or unnecessary
4 delays between the finding of a deficiency and the
5 imposition of sanctions; and

6 “(D) the Secretary provides the organization
7 with reasonable notice and opportunity for hearing
8 (including the right to appeal an initial decision) be-
9 fore imposing any sanction or terminating the con-
10 tract.”.

11 (4) CONFORMING AMENDMENTS.—

12 (A) IN GENERAL.—Section 1876(i)(6)(B)
13 of such Act (42 U.S.C. 1395mm(i)(6)(B)) is
14 amended by striking the second sentence.

15 (B) PROCEDURAL PROVISIONS.—Section
16 1876(i)(6) of such Act (42 U.S.C.
17 1395mm(i)(6)) is further amended by adding at
18 the end the following new subparagraph:

19 “(D) The provisions of section 1128A (other than
20 subsections (a) and (b)) shall apply to a civil money pen-
21 alty under subparagraph (A) or (B) in the same manner
22 as they apply to a civil money penalty or proceeding under
23 section 1128A(a).”.

24 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
25 TIONS.—

1 (1) REQUIREMENT FOR WRITTEN AGREE-
2 MENT.—Section 1876(i)(7)(A) of the Social Security
3 Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by
4 striking “an agreement” and inserting “a written
5 agreement”.

6 (2) DEVELOPMENT OF MODEL AGREEMENT.—
7 Not later than July 1, 1995, the Secretary shall de-
8 velop a model of the agreement that an eligible orga-
9 nization with a risk-sharing contract under section
10 1876 of the Social Security Act must enter into with
11 an entity providing peer review services with respect
12 to services provided by the organization under sec-
13 tion 1876(i)(7)(A) of such Act.

14 (3) REPORT BY GAO.—

15 (A) STUDY.—The Comptroller General of
16 the United States shall conduct a study of the
17 costs incurred by eligible organizations with
18 risk-sharing contracts under section 1876(b) of
19 such Act of complying with the requirement of
20 entering into a written agreement with an en-
21 tity providing peer review services with respect
22 to services provided by the organization, to-
23 gether with an analysis of how information gen-
24 erated by such entities is used by the Secretary

1 to assess the quality of services provided by
2 such eligible organizations.

3 (B) REPORT TO CONGRESS.—Not later
4 than July 1, 1997, the Comptroller General
5 shall submit a report to the Committee on
6 Ways and Means and the Committee on Energy
7 and Commerce of the House of Representatives
8 and the Committee on Finance and the Special
9 Committee on Aging of the Senate on the study
10 conducted under subparagraph (A).

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply with respect to contract years be-
13 ginning on or after January 1, 1995.

14 **SEC. 718. EFFECTIVE DATE.**

15 The amendments made by this subtitle shall take ef-
16 fect January 1, 1995.

17 **Subtitle C—Administrative and**
18 **Miscellaneous Provisions**

19 **SEC. 721. ESTABLISHMENT OF THE HEALTH CARE FRAUD**
20 **AND ABUSE DATA COLLECTION PROGRAM.**

21 (a) FINDINGS.—The Congress finds the following:

22 (1) Fraud and abuse with respect to the deliv-
23 ery of and payment for health care services is a sig-
24 nificant contributor to the growing costs of the Na-
25 tion's health care.

1 (2) Control of fraud and abuse in health care
2 services warrants greater efforts of coordination
3 than those that can be undertaken by individual
4 States or the various Federal, State, and local law
5 enforcement programs.

6 (3) There is a national need to coordinate infor-
7 mation about health care providers and entities that
8 have engaged in fraud and abuse in the delivery of
9 and payment for health care services.

10 (4) There is no comprehensive national data
11 collection program for the reporting of public infor-
12 mation about final adverse actions against health
13 care providers, suppliers, or licensed health care
14 practitioners that have engaged in fraud and abuse
15 in the delivery of and payment for health care serv-
16 ices.

17 (5) A comprehensive national data collection
18 program for the reporting of public information
19 about final adverse actions will facilitate the enforce-
20 ment of the provisions of the Social Security Act and
21 other statutes applicable to health care fraud and
22 abuse.

23 (b) GENERAL PURPOSE.—Not later than January 1,
24 1995, the Secretary shall establish a national health care
25 fraud and abuse data collection program for the reporting

1 of final adverse actions (not including settlements in which
2 no findings of liability have been made) against health
3 care providers, suppliers, or practitioners as required by
4 subsection (c), with access as set forth in subsection (d).

5 (c) REPORTING OF INFORMATION.—

6 (1) IN GENERAL.—Each government agency
7 and health care plan shall report any final adverse
8 action (not including settlements in which no find-
9 ings of liability have been made) taken against a
10 health care provider, supplier, or practitioner.

11 (2) INFORMATION TO BE REPORTED.—The in-
12 formation to be reported under paragraph (1) in-
13 cludes:

14 (A) The name of any health care provider,
15 supplier, or practitioner who is the subject of a
16 final adverse action.

17 (B) The name (if known) of any health
18 care entity with which a health care provider,
19 supplier, or practitioner is affiliated or associ-
20 ated.

21 (C) The nature of the final adverse action.

22 (D) A description of the acts or omissions
23 and injuries upon which the final adverse action
24 was based, and such other information as the
25 Secretary determines by regulation is required

1 for appropriate interpretation of information re-
2 ported under this section.

3 (3) CONFIDENTIALITY.—In determining what
4 information is required, the Secretary shall include
5 procedures to assure that the privacy of individuals
6 receiving health care services is appropriately pro-
7 tected.

8 (4) TIMING AND FORM OF REPORTING.—The
9 information required to be reported under this sub-
10 section shall be reported regularly (but not less often
11 than monthly) and in such form and manner as the
12 Secretary prescribes. Such information shall first be
13 required to be reported on a date specified by the
14 Secretary.

15 (5) TO WHOM REPORTED.—The information re-
16 quired to be reported under this subsection shall be
17 reported to the Secretary.

18 (d) DISCLOSURE AND CORRECTION OF INFORMA-
19 TION.—

20 (1) DISCLOSURE.—With respect to the informa-
21 tion about final adverse actions (not including settle-
22 ments in which no findings of liability have been
23 made) reported to the Secretary under this section
24 respecting a health care provider, supplier, or practi-

1 tioner, the Secretary shall, by regulation, provide
2 for—

3 (A) disclosure of the information, upon re-
4 quest, to the health care provider, supplier, or
5 licensed practitioner, and

6 (B) procedures in the case of disputed ac-
7 curacy of the information.

8 (2) CORRECTIONS.—Each Government agency
9 and health care plan shall report corrections of in-
10 formation already reported about any final adverse
11 action taken against a health care provider, supplier,
12 or practitioner, in such form and manner that the
13 Secretary prescribes by regulation.

14 (e) ACCESS TO REPORTED INFORMATION.—

15 (1) AVAILABILITY.—The information in this
16 database shall be available to Federal and State gov-
17 ernment agencies and health care plans pursuant to
18 procedures that the Secretary shall provide by regu-
19 lation.

20 (2) FEES FOR DISCLOSURE.—The Secretary
21 may establish or approve reasonable fees for the dis-
22 closure of information in this database. The amount
23 of such a fee may not exceed the costs of processing
24 the requests for disclosure and of providing such in-
25 formation. Such fees shall be available to the Sec-

1 retary or, in the Secretary's discretion to the agency
2 designated under this section to cover such costs.

3 (f) PROTECTION FROM LIABILITY FOR REPORT-
4 ING.—No person or entity, including the agency des-
5 ignated by the Secretary in subsection (c)(5) shall be held
6 liable in any civil action with respect to any report made
7 as required by this section, without knowledge of the fal-
8 sity of the information contained in the report.

9 (g) DEFINITIONS AND SPECIAL RULES.—For pur-
10 poses of this section:

11 (1) The term “final adverse action” includes:

12 (A) Civil judgments against a health care
13 provider in Federal or State court related to the
14 delivery of a health care item or service.

15 (B) Federal or State criminal convictions
16 related to the delivery of a health care item or
17 service.

18 (C) Actions by Federal or State agencies
19 responsible for the licensing and certification of
20 health care providers, suppliers, and licensed
21 health care practitioners, including—

22 (i) formal or official actions, such as
23 revocation or suspension of a license (and
24 the length of any such suspension), rep-
25 rimand, censure or probation,

1 (ii) any other loss of license of the
2 provider, supplier, or practitioner, by oper-
3 ation of law, or

4 (iii) any other negative action or find-
5 ing by such Federal or State agency that
6 is publicly available information.

7 (D) Exclusion from participation in Fed-
8 eral or State health care programs.

9 (E) Any other adjudicated actions or deci-
10 sions that the Secretary shall establish by regu-
11 lation.

12 (2) The terms “licensed health care practi-
13 tioner”, “licensed practitioner”, and “practitioner”
14 mean, with respect to a State, an individual who is
15 licensed or otherwise authorized by the State to pro-
16 vide health care services (or any individual who,
17 without authority holds himself or herself out to be
18 so licensed or authorized).

19 (3) The term “health care provider” means a
20 provider of services as defined in section 1861(u) of
21 the Social Security Act, and any entity, including a
22 health maintenance organization, group medical
23 practice, or any other entity listed by the Secretary
24 in regulation, that provides health care services.

1 (4) The term “supplier” means a supplier of
2 health care items and services described in section
3 1819 (a) and (b), and section 1861 of the Social Se-
4 curity Act.

5 (5) The term “Government agency” shall in-
6 clude:

7 (A) The Department of Justice.

8 (B) The Department of Health and
9 Human Services.

10 (C) Any other Federal agency that either
11 administers or provides payment for the deliv-
12 ery of health care services, including, but not
13 limited to the Department of Defense and the
14 Veterans’ Administration.

15 (D) State law enforcement agencies.

16 (E) State medicaid fraud and abuse units.

17 (F) Federal or State agencies responsible
18 for the licensing and certification of health care
19 providers and licensed health care practitioners.

20 (6) The term “health care plan” has the mean-
21 ing given to such term by section 1128(i) of the So-
22 cial Security Act.

23 (7) For purposes of paragraph (2), the exist-
24 ence of a conviction shall be determined under para-

1 graph (4) of section 1128(j) of the Social Security
2 Act.

3 (h) CONFORMING AMENDMENT.—Section 1921(d) of
4 the Social Security Act is amended by inserting “and sec-
5 tion 721 of the America’s Health Care Option Act” after
6 “section 422 of the Health Care Quality Improvement Act
7 of 1986”.

8 **Subtitle D—Amendments to**
9 **Criminal Law**

10 **SEC. 731. HEALTH CARE FRAUD.**

11 (a) IN GENERAL.—

12 (1) FINES AND IMPRISONMENT FOR HEALTH
13 CARE FRAUD VIOLATIONS.—Chapter 63 of title 18,
14 United States Code, is amended by adding at the
15 end the following new section:

16 **“§ 1347. Health care fraud**

17 “(a) Whoever knowingly executes, or attempts to exe-
18 cute, a scheme or artifice—

19 “(1) to defraud any health care plan or other
20 person, in connection with the delivery of or pay-
21 ment for health care benefits, items, or services; or

22 “(2) to obtain, by means of false or fraudulent
23 pretenses, representations, or promises, any of the
24 money or property owned by, or under the custody
25 or control of, any health care plan, or person in con-

1 nection with the delivery of or payment for health
2 care benefits, items, or services;
3 shall be fined under this title or imprisoned not more than
4 10 years, or both. If the violation results in serious bodily
5 injury (as defined in section 1365(g)(3) of this title), such
6 person shall be imprisoned for any term of years.

7 “(b) For purposes of this section, the term ‘health
8 care plan’ means a federally funded public program, or
9 a private plan or other arrangement for the delivery of
10 or payment for health care items or services.”.

11 (2) CLERICAL AMENDMENT.—The table of sec-
12 tions at the beginning of chapter 63 of title 18,
13 United States Code, is amended by adding at the
14 end the following:

“1347. Health care fraud.”.

15 (b) CRIMINAL FINES DEPOSITED IN THE ANTI-
16 FRAUD AND ABUSE TRUST FUND.—The Secretary of the
17 Treasury shall deposit into the Anti-Fraud and Abuse
18 Trust Fund established under section 701(b) an amount
19 equal to the criminal fines imposed under section 1347
20 of title 18, United States Code (relating to health care
21 fraud).

1 **SEC. 732. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
2 **FENSES.**

3 (a) IN GENERAL.—Section 982(a) of title 18, United
4 States Code, is amended by adding after paragraph (5)
5 the following new paragraph:

6 “(6)(A) The court, in imposing sentence on a person
7 convicted of a Federal health care offense, shall order the
8 person to forfeit property, real or personal, that—

9 “(i) is used in the commission of the offense if
10 the offense results in a financial loss or gain of
11 \$50,000 or more; or

12 “(ii) constitutes or is derived from proceeds
13 traceable to the commission of the offense.

14 “(B) For purposes of this paragraph, the term ‘Fed-
15 eral health care offense’ means a violation of, or a criminal
16 conspiracy to violate—

17 “(i) section 1347 of this title;

18 “(ii) section 1128B of the Social Security Act;

19 “(iii) sections 287, 371, 664, 666, 1001, 1027,
20 1341, 1343, or 1954 of this title if the violation or
21 conspiracy relates to health care fraud; and

22 “(iv) section 501 or 511 of the Employee Re-
23 tirement Income Security Act of 1974, if the viola-
24 tion or conspiracy relates to health care fraud.”.

25 (b) PROPERTY FORFEITED DEPOSITED IN ANTI-
26 FRAUD AND ABUSE TRUST FUND.—The Secretary of the

1 Treasury shall deposit into the Anti-Fraud and Abuse
 2 Trust Fund established under section 701(b) an amount
 3 equal to amounts resulting from forfeiture of property by
 4 reason of a Federal health care offense pursuant to section
 5 982(a)(6) of title 18, United States Code.

6 **SEC. 733. INJUNCTIVE RELIEF RELATING TO FEDERAL**
 7 **HEALTH CARE OFFENSES.**

8 Section 1345(a)(1) of title 18, United States Code,
 9 is amended—

10 (1) by striking “or” at the end of subparagraph
 11 (A);

12 (2) by inserting “or” at the end of subpara-
 13 graph (B); and

14 (3) by adding at the end the following:

15 “(C) committing or about to commit a
 16 Federal health care offense (as defined in sec-
 17 tion 982(a)(6)(B) of this title);”.

18 **Subtitle E—Amendments to Civil**
 19 **False Claims Act**

20 **SEC. 741. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.**

21 (a) IN GENERAL.—Section 3729 of title 31, United
 22 States Code, is amended—

23 (1) in subsection (a)(7), by inserting “or to a
 24 health care plan,” after “property to the Govern-
 25 ment,”;

1 (2) in the matter following subsection (a)(7), by
2 inserting “or health care plan” before “sustains be-
3 cause of the act of that person,”;

4 (3) at the end of the first sentence of sub-
5 section (a), by inserting “or health care plan” before
6 “sustains because of the act of the person.”;

7 (4) in subsection (c)—

8 (A) by inserting “the term” after “sec-
9 tion,”; and

10 (B) by adding at the end the following:

11 “The term also includes any request or demand,
12 whether under contract or otherwise, for money
13 or property which is made or presented to a
14 health care plan.”; and

15 (5) by adding at the end the following:

16 “(f) HEALTH CARE PLAN DEFINED.—For purposes
17 of this section, the term ‘health care plan’ means a feder-
18 ally funded public program for the delivery of or payment
19 for health care items or services.”.

20 (b) PENALTIES AND DAMAGES DEPOSITED INTO THE
21 ANTI-FRAUD AND ABUSE TRUST FUND.—The Secretary
22 of the Treasury shall deposit into the Anti-Fraud and
23 Abuse Trust Fund established under section 701(b) an
24 amount equal to penalties and damages imposed under
25 section 3729 of title 31, United States Code, in cases in-

1 involving claims related to the provision of health care items
 2 and services (other than funds awarded to a relator or
 3 for restitution).

4 **TITLE VIII—MEDICARE AND** 5 **MEDICAID**

6 **SEC. 800. REFERENCES TO SOCIAL SECURITY ACT.**

7 Except as otherwise specifically provided, whenever in
 8 this title an amendment is expressed in terms of an
 9 amendment to or repeal of a section or other provision,
 10 the reference shall be considered to be made to that sec-
 11 tion or other provision of the Social Security Act.

12 **Subtitle A—Medicare**

13 **PART I—INTEGRATION OF MEDICARE**

14 **BENEFICIARIES INTO THE PRIVATE MARKET**

15 **SEC. 801. STUDY ON INTEGRATION OF MEDICARE BENE-** 16 **FICIARIES.**

17 (a) IN GENERAL.—The Secretary of Health and
 18 Human Services (hereafter in this section referred to as
 19 the “Secretary”) shall study—

20 (1) allowing payment under title XVIII of the
 21 Social Security Act on behalf of medicare bene-
 22 ficiaries that opt—

23 (A) to enroll in certified health plans (as
 24 defined in section 21003(b) of the Social Secu-
 25 rity Act); and

1 (B) to establish medical savings accounts
2 (in accordance with section 213 of the Ameri-
3 ca's Health Care Option Act); and

4 (2) allowing payment under title XVIII of the
5 Social Security Act on behalf of medicare bene-
6 ficiaries who are military retirees that opt to enroll
7 in health plans sponsored by the Department of De-
8 fense or other appropriate Federal health care pro-
9 grams.

10 (b) RECOMMENDATIONS.—Not later than 1 year
11 after the date of the enactment of this Act, the Secretary
12 shall submit recommendations to Congress on each of the
13 matters studied under subsection (a).

14 **SEC. 802. IMPROVEMENTS TO RISK CONTRACTS.**

15 (a) RATING AREAS.—Section 1876(a)(1)(F)(ii) (42
16 U.S.C. 1395mm(a)(1)(F)(ii)) is amended by striking
17 “county (or equivalent area)” and inserting “Metropolitan
18 Statistical Area (as defined by the Office of Management
19 and Budget), New England County Metropolitan Area, or
20 other appropriate geographic area outside a Metropolitan
21 Statistical Area or a New England County Metropolitan
22 Area (hereafter in this section referred to as a ‘rating
23 area’)”.

24 (b) PERIOD OF ENROLLMENT.—Section 1876(c)(3)
25 (42 U.S.C. 1395mm(c)(3)) is amended—

1 (1) in subparagraph (A)(i), after “of at least 30
2 days duration every year”, by inserting “(which may
3 be specified by the Secretary)”;

4 (2) in subparagraph (B), by striking “as of”
5 and inserting “, at the option of the organization, (i)
6 during an annual period as approved by the Sec-
7 retary, or (ii) as of”;

8 (3) in subparagraph (E)—

9 (A) by striking “and” in clause (iv),

10 (B) by striking the period in clause (v) and
11 inserting “, and”, and

12 (C) by adding at the end the following new
13 clause:

14 “(vi) the option chosen by the plan
15 under clause (i) or (ii) of subparagraph
16 (B) with respect to termination of enroll-
17 ment by an individual.”.

18 (c) MARKETING MATERIALS.—Section 1876(c)(3)(C)
19 (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at
20 the end the following: “The Secretary shall develop com-
21 parative materials with respect to all eligible organizations
22 in an area (and with respect to the program established
23 under this title for individuals not enrolled with such an
24 organization) for distribution by such organizations or the

1 Secretary to individuals eligible to enroll under this sec-
2 tion.”.

3 (d) FIFTY-FIFTY RULE.—Section 1876(f) (42 U.S.C.
4 1395mm(f)) is amended—

5 (1) by amending paragraph (2) to read as fol-
6 lows:

7 “(2) The Secretary may modify or waive the re-
8 quirement imposed by paragraph (1) if an eligible
9 organization demonstrates that it provides for ade-
10 quate quality of care for individuals enrolled under
11 this section by—

12 “(A) meeting the quality standards for or-
13 ganizations with contracts under this section;

14 “(B) meeting the fiscal soundness require-
15 ments under this section;

16 “(C) demonstrating successful operational
17 experience as an eligible organization under this
18 section for at least the 3 years immediately pre-
19 ceding an application for a waiver under this
20 paragraph; and

21 “(D) demonstrating that the number of in-
22 dividuals enrolled in the plan or its parent orga-
23 nization is at least 50,000 at the time of appli-
24 cation for a waiver under this paragraph.

1 In making a determination under subparagraph (A)
2 with respect to an eligible organization, the Sec-
3 retary may accept quality performance standards as
4 measured by private organizations acceptable to the
5 Secretary or organizations designated by the Sec-
6 retary, including peer review organizations.”; and

7 (2) by adding at the end the following new
8 paragraph:

9 “(4) The Secretary may terminate the require-
10 ment under paragraph (1) when the Secretary deter-
11 mines that health plans have established alternative
12 quality assurance mechanisms that effectively pro-
13 vide sufficient quality safeguards.”.

14 (e) REBATES.—Section 1876(g)(2) (42 U.S.C.
15 1395mm(g)(2)) is amended in the matter following sub-
16 paragraph (B) by striking “community rate (as so re-
17 duced); except” and inserting “community rate (as so re-
18 duced) or, at the election of the plan, a cash rebate equal
19 to such difference; except”.

20 (f) DIRECT CALCULATION OF AAPCC.—Section
21 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended by
22 striking “actual experience” and all that follows through
23 “actuarial equivalence)” and inserting “actual experience
24 in a rating area”.

25 (g) DEMONSTRATION PROJECT.—

1 (1) IN GENERAL.—Not later than 18 months
2 after the date of the enactment of this Act, the Sec-
3 retary of Health and Human Services shall establish
4 a demonstration project under which any eligible or-
5 ganization that—

6 (A) has a risk contract under section 1876
7 of the Social Security Act (42 U.S.C. 1395mm),
8 and

9 (B) serves individuals enrolled under such
10 section in a rating area (as defined under sec-
11 tion 1876(a)(1)(F)(ii) of such Act),

12 is paid, with respect to such individuals, on the basis
13 of a payment methodology that blends market-based
14 premiums and the average per capita fee-for-service
15 costs for individuals eligible to enroll under such sec-
16 tion for the area and gives greater weight to market-
17 based premiums in areas in which a greater propor-
18 tion of such individuals are enrolled with such orga-
19 nizations.

20 (2) DESIGNATION OF AREAS.—The Secretary
21 may designate a rating area (as defined by the Sec-
22 retary under section 1876(a)(1)(F)(ii) of the Social
23 Security Act (42 U.S.C. 1395mm(a)(1)(F)(ii))) for
24 participation in the demonstration established under
25 paragraph (1) only if—

1 (A) the eligible organizations with a con-
2 tract under section 1876 of the Social Security
3 Act serving such area submit an application to
4 participate in the demonstration project in such
5 form and manner, and at such time, as the Sec-
6 retary may designate, and

7 (B)(i) the rating area has more than one
8 eligible organization with a contract serving
9 such area,

10 (ii) the rating area has adequate enroll-
11 ment of individuals who are entitled to benefits
12 under part A of title XVIII of such Act in eligi-
13 ble organizations with a contract under section
14 1876 of such Act (as determined by the Sec-
15 retary), and

16 (iii) the adjusted average per capita cost
17 for such rating area for part B services under
18 title XVIII of such Act as determined in ac-
19 cordance with such section is less than the
20 United States per capita cost for part B serv-
21 ices under such title.

22 (h) EXTENSION OF SOCIAL HEALTH MAINTENANCE
23 ORGANIZATIONS.—Section 4018(b) of the Omnibus Budg-
24 et Reconciliation Act of 1987, as amended by section
25 4207(b)(4)(B) of the Omnibus Budget Reconciliation Act

1 of 1990 and section 13567(a) of the Omnibus Budget Rec-
2 onciliation Act of 1993, is amended—

3 (1) in paragraph (1), by striking “December
4 31, 1997” and inserting “December 31, 1999”; and

5 (2) in paragraph (4), by striking “March 31,
6 1998” and inserting “March 31, 2000”.

7 (i) MILITARY ADJUSTMENT.—Section 1876(a)(1)(B)
8 (42 U.S.C. 1395mm(a)(1)(B)) is amended by inserting
9 “use or nonuse of Veteran’s Administration, military
10 treatment and uniformed services treatment facilities, and
11 associated physicians, providers, and suppliers,” after
12 “disability status,”.

13 (j) EFFECTIVE DATE.—The amendments made by
14 subsections (a), (b), (c), (d), (e), (f), and (i) shall apply
15 to contracts entered into or renewed on or after January
16 1, 1996.

17 **SEC. 803. MEDICARE SELECT.**

18 (a) AMENDMENTS TO PROVISIONS RELATING TO
19 MEDICARE SELECT POLICIES.—

20 (1) PERMITTING MEDICARE SELECT POLICIES
21 IN ALL STATES.—Subsection (c) of section 4358 of
22 the Omnibus Budget Reconciliation Act of 1990 is
23 hereby repealed.

1 (2) REQUIREMENTS OF MEDICARE SELECT
2 POLICIES.—Section 1882(t)(1) (42 U.S.C.
3 1395ss(t)(1)) is amended to read as follows:

4 “(1)(A) If a medicare supplemental policy meets the
5 requirements of the 1991 NAIC Model Regulation or 1991
6 Federal Regulation and otherwise complies with the re-
7 quirements of this section except that—

8 “(i) the benefits under such policy are re-
9 stricted to items and services furnished by certain
10 entities (or reduced benefits are provided when items
11 or services are furnished by other entities), and

12 “(ii) in the case of a policy described in sub-
13 paragraph (C)(i)—

14 “(I) the benefits under such policy are not
15 one of the groups or packages of benefits de-
16 scribed in subsection (p)(2)(A),

17 “(II) except for nominal copayments im-
18 posed for services covered under part B of this
19 title, such benefits include at least the core
20 group of basic benefits described in subsection
21 (p)(2)(B), and

22 “(III) an enrollee’s liability under such pol-
23 icy for physician’s services covered under part
24 B of this title is limited to the nominal
25 copayments described in subclause (II),

1 the policy shall nevertheless be treated as meeting
2 those requirements if the policy meets the require-
3 ments of subparagraph (B).

4 “(B) A policy meets the requirements of this sub-
5 paragraph if—

6 “(i) full benefits are provided for items and
7 services furnished through a network of entities
8 which have entered into contracts or agreements
9 with the issuer of the policy,

10 “(ii) full benefits are provided for items and
11 services furnished by other entities if the services are
12 medically necessary and immediately required be-
13 cause of an unforeseen illness, injury, or condition
14 and it is not reasonable given the circumstances to
15 obtain the services through the network,

16 “(iii) the network offers sufficient access,

17 “(iv) the issuer of the policy has arrangements
18 for an ongoing quality assurance program for items
19 and services furnished through the network,

20 “(v)(I) the issuer of the policy provides to each
21 enrollee at the time of enrollment an explanation
22 of—

23 “(aa) the restrictions on payment under
24 the policy for services furnished other than by
25 or through the network,

1 “(bb) out of area coverage under the pol-
2 icy,

3 “(cc) the policy’s coverage of emergency
4 services and urgently needed care, and

5 “(dd) the availability of a policy through
6 the entity that meets the 1991 Model NAIC
7 Regulation or 1991 Federal Regulation without
8 regard to this subsection and the premium
9 charged for such policy, and

10 “(II) each enrollee prior to enrollment acknowl-
11 edges receipt of the explanation provided under
12 subclause (I), and

13 “(vi) the issuer of the policy makes available to
14 individuals, in addition to the policy described in this
15 subsection, any policy (otherwise offered by the is-
16 suer to individuals in the State) that meets the 1991
17 Model NAIC Regulation or 1991 Federal Regulation
18 and other requirements of this section without re-
19 gard to this subsection.

20 “(C) (i) A policy described in this subparagraph—

21 “(I) is offered by an eligible organization (as
22 defined in section 1876(b)),

23 “(II) is not a policy or plan providing benefits
24 pursuant to a contract under section 1876 or an ap-
25 proved demonstration project described in section

1 603(c) of the Social Security Amendments of 1983,
2 section 2355 of the Deficit Reduction Act of 1984,
3 or section 9412(b) of the Omnibus Budget Reconcili-
4 ation Act of 1986, and

5 “(III) provides benefits which, when combined
6 with benefits which are available under this title, are
7 substantially similar to benefits under policies of-
8 fered to individuals who are not entitled to benefits
9 under this title.

10 “(ii) In making a determination under subclause (III)
11 of clause (i) as to whether certain benefits are substan-
12 tially similar, there shall not be taken into account, except
13 in the case of preventive services, benefits provided under
14 policies offered to individuals who are not entitled to bene-
15 fits under this title which are in addition to the benefits
16 covered by this title and which are benefits an entity must
17 provide in order to meet the definition of an eligible orga-
18 nization under section 1876(b)(1).’”.

19 (b) RENEWABILITY OF MEDICARE SELECT POLI-
20 CIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is
21 amended—

22 (1) by striking “(1) Each” and inserting
23 “(1)(A) Except as provided in subparagraph (B),
24 each”;

1 (2) by redesignating subparagraphs (A) and
2 (B) as clauses (i) and (ii), respectively; and

3 (3) by adding at the end the following new sub-
4 paragraph:

5 “(B)(i) In the case of a policy that meets the
6 requirements of subsection (t), an issuer may cancel
7 or nonrenew such policy with respect to an individ-
8 ual who leaves the service area of such policy; except
9 that, if such individual moves to a geographic area
10 where such issuer, or where an affiliate of such is-
11 suer, is issuing medicare supplemental policies, such
12 individual must be permitted to enroll in any medi-
13 care supplemental policy offered by such issuer or
14 affiliate that provides benefits comparable to or less
15 than the benefits provided in the policy being can-
16 celed or nonrenewed. An individual whose coverage
17 is canceled or nonrenewed under this subparagraph
18 shall, as part of the notice of termination or
19 nonrenewal, be notified of the right to enroll in other
20 medicare supplemental policies offered by the issuer
21 or its affiliates.

22 “(ii) For purposes of this subparagraph, the
23 term ‘affiliate’ shall have the meaning given such
24 term by the 1991 NAIC Model Regulation.”.

1 (c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C.
2 1395ss(t)(2)) is amended—

3 (1) by striking “(2)” and inserting “(2)(A)”;

4 (2) by redesignating subparagraphs (A), (B),
5 (C), and (D) as clauses (i), (ii), (iii), and (iv), re-
6 spectively;

7 (3) in clause (iv), as redesignated—

8 (A) by striking “paragraph (1)(E)(i)” and
9 inserting “paragraph (1)(B)(v)(I); and

10 (B) by striking “paragraph (1)(E)(ii)” and
11 inserting “paragraph (1)(B)(v)(II)”;

12 (4) by striking “the previous sentence” and in-
13 serting “this subparagraph”; and

14 (5) by adding at the end the following new sub-
15 paragraph:

16 “(B) If the Secretary determines that an issuer of
17 a policy approved under paragraph (1) has made a mis-
18 representation to the Secretary or has provided the Sec-
19 retary with false information regarding such policy, the
20 issuer is subject to a civil money penalty in an amount
21 not to exceed \$100,000 for each such determination. The
22 provisions of section 1128A (other than the first sentence
23 of subsection (a) and other than subsection (b)) shall
24 apply to a civil money penalty under this subparagraph

1 in the same manner as such provisions apply to a penalty
2 or proceeding under section 1128A(a).”.

3 (d) EFFECTIVE DATES.—

4 (1) NAIC STANDARDS.—If, within 9 months
5 after the date of the enactment of this Act, the Na-
6 tional Association of Insurance Commissioners
7 (hereafter in this subsection referred to as the
8 “NAIC”) makes changes in the 1991 NAIC Model
9 Regulation (as defined in section 1882(p)(1)(A) of
10 the Social Security Act) to incorporate the additional
11 requirements imposed by the amendments made by
12 this section, section 1882(g)(2)(A) of such Act shall
13 be applied in each State, effective for policies issued
14 to policyholders on and after the date specified in
15 paragraph (3), as if the reference to the Model Reg-
16 ulation adopted on June 6, 1979, were a reference
17 to the 1991 NAIC Model Regulation (as so defined)
18 as changed under this paragraph (such changed
19 Regulation referred to in this subsection as the
20 “1995 NAIC Model Regulation”).

21 (2) SECRETARY STANDARDS.—If the NAIC
22 does not make changes in the 1991 NAIC Model
23 Regulation (as so defined) within the 9-month period
24 specified in paragraph (1), the Secretary of Health
25 and Human Services (hereafter in this subsection re-

1 ferred to as the “Secretary”) shall promulgate a reg-
2 ulation and section 1882(g)(2)(A) of the Social Se-
3 curity Act shall be applied in each State, effective
4 for policies issued to policyholders on and after the
5 date specified in paragraph (3), as if the reference
6 to the Model Regulation adopted on June 6, 1979,
7 were a reference to the 1991 NAIC Model Regula-
8 tion (as so defined) as changed by the Secretary
9 under this paragraph (such changed Regulation re-
10 ferred to in this subsection as the “1995 Federal
11 Regulation”).

12 (3) DATE SPECIFIED.—

13 (A) IN GENERAL.—Subject to subpara-
14 graph (B), the date specified in this paragraph
15 for a State is the earlier of—

16 (i) the date the State adopts the 1995
17 NAIC Model Regulation or the 1995 Fed-
18 eral Regulation, or

19 (ii) 1 year after the date the NAIC or
20 the Secretary first adopts such regulations.

21 (B) ADDITIONAL LEGISLATIVE ACTION RE-
22 QUIRED.—In the case of a State which the Sec-
23 retary identifies, in consultation with the NAIC,
24 as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART II—PROVISIONS RELATED TO PART A

SEC. 811. INPATIENT HOSPITAL SERVICES UPDATE FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

1 “(XII) for fiscal years 1997 through 2000, the
 2 market basket percentage minus 1.0 percentage
 3 points for hospitals in all areas, and”; and

4 (2) in subclause (XIII), by striking “1998” and
 5 inserting “2001”.

6 **SEC. 812. REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-**
 7 **ED COSTS FOR INPATIENT HOSPITAL SERV-**
 8 **ICES.**

9 (a) REDUCTION IN BASE PAYMENT RATES FOR PPS
 10 HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C.
 11 1395ww(g)(1)(A)) is amended by adding at the end the
 12 following new sentence: “In addition to the reduction de-
 13 scribed in the preceding sentence, for discharges occurring
 14 after September 30, 1995, the Secretary shall reduce by
 15 7.31 percent the unadjusted standard Federal capital pay-
 16 ment rate (as described in 42 CFR 412.308(c), as in effect
 17 on the date of the enactment of the America’s Health Care
 18 Option Act) and shall reduce by 10.41 percent the
 19 unadjusted hospital-specific rate (as described in 42 CFR
 20 412.328(e)(1), as in effect on the date of the enactment
 21 of the America’s Health Care Option Act).”.

22 (b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT
 23 HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1))
 24 is amended by adding at the end the following new sub-
 25 paragraph:

1 “(T) Such regulations shall provide that, in determin-
 2 ing the amount of the payments that may be made under
 3 this title with respect to the capital-related costs of inpa-
 4 tient hospital services furnished by a hospital that is not
 5 a subsection (d) hospital (as defined in section
 6 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital
 7 (as defined in section 1886(d)(9)(A)), the Secretary shall
 8 reduce the amounts of such payments otherwise estab-
 9 lished under this title by 15 percent for payments attrib-
 10 utable to portions of cost reporting periods occurring dur-
 11 ing each of the fiscal years 1996 through 2003.”.

12 **SEC. 813. REVISIONS TO PAYMENT ADJUSTMENTS FOR DIS-**
 13 **PROPORTIONATE SHARE HOSPITALS IN PAR-**
 14 **TICIPATING STATES.**

15 (a) APPLICATION OF ALTERNATIVE ADJUST-
 16 MENTS.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is
 17 amended—

18 (1) by redesignating subparagraphs (H) and (I)
 19 as subparagraphs (I) and (J); and

20 (2) by inserting after subparagraph (G) the fol-
 21 lowing new subparagraph:

22 “(H)(i) In accordance with this subparagraph, the
 23 Secretary shall provide for an additional payment for each
 24 subsection (d) hospital that is located in a participating
 25 State under the America’s Health Care Option Act during

1 a cost reporting period and that meets the eligibility re-
2 quirements described in clause (iii).

3 “(ii) The amount of the additional payment made
4 under clause (i) for each discharge shall be determined
5 by multiplying—

6 “(I) the sum of the amount determined under
7 paragraph (1)(A)(ii)(II) (or, if applicable, the
8 amount determined under paragraph (1)(A)(iii)) and
9 the amount paid to the hospital under subparagraph
10 (A) for the discharge, by

11 “(II) the SSI adjustment percentage for the
12 cost reporting period in which the discharge occurs
13 (as defined in clause (iv)).

14 “(iii) A hospital meets the eligibility requirements de-
15 scribed in this clause with respect to a cost reporting pe-
16 riod if—

17 “(I) in the case of a hospital that is located in
18 an urban area and that has more than 100 beds, the
19 hospital’s SSI patient percentage (as defined in
20 clause (v)) for the cost reporting period is not less
21 than 5.5 percent;

22 “(II) in the case of a hospital that is located in
23 an urban area and that has less than 100 beds, the
24 hospital’s SSI patient percentage is not less than 17
25 percent;

1 “(III) in the case of a hospital that is classified
 2 as a rural referral center under subparagraph (C) or
 3 a sole community hospital under subparagraph (D),
 4 the hospital’s SSI patient percentage for the cost re-
 5 porting period is not less than 23 percent; and

6 “(IV) in the case of any other hospital, the hos-
 7 pital’s SSI patient percentage is not less than 23
 8 percent.

9 “(iv) For purposes of clause (ii), the ‘SSI adjustment
 10 percentage’ applicable to a hospital for a cost reporting
 11 period is equal to—

12 “(I) in the case of a hospital described in clause
 13 (iii)(I), the percentage determined in accordance
 14 with the following formula: e to the n th power $- 1$,
 15 where ‘ e ’ is the natural antilog of 1 and where ‘ n ’
 16 is equal to $(1.37 * (\text{the hospital’s SSI patient per-}$
 17 centage for the cost reporting period $- .055))$;

18 “(II) in the case of a hospital described in
 19 clause (iii)(II) or clause (iii)(IV), 2 percent; and

20 “(III) in the case of a hospital described in
 21 clause (iii)(III), the sum of 2 percent and .30 per-
 22 cent of the difference between the hospital’s SSI pa-
 23 tient percentage for the cost reporting period and 23
 24 percent.

1 “(v) In this subparagraph, a hospital’s ‘SSI patient
2 percentage’ with respect to a cost reporting period is equal
3 to the fraction (expressed as a percentage)—

4 “(I) the numerator of which is the number of
5 the hospital’s patient days for such period which
6 were made up of patients who (for such days) were
7 entitled to benefits under part A and were entitled
8 to supplementary security income benefits (excluding
9 State supplementation) under title XVI; and

10 “(II) the denominator of which is the number
11 of the hospital’s patient days for such period which
12 were made up of patients who (for such days) were
13 entitled to benefits under part A.”.

14 (b) NO STANDARDIZATION RESULTING FROM RE-
15 Duction.—Section 1886(d)(2)(C)(iv) (42 U.S.C.
16 1395ww(d)(2)(C)(iv)) is amended—

17 (1) by striking “exclude additional payments”
18 and inserting “adjust such estimate for changes in
19 payments”;

20 (2) by striking “1989 or” and inserting
21 “1989,”; and

22 (3) by striking the period at the end and insert-
23 ing the following: “, or the enactment of section 813
24 of the America’s Health Care Option Act.”.

1 (c) CONFORMING AMENDMENT.—Section
 2 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is
 3 amended in the matter preceding subclause (I) by insert-
 4 ing after “hospital” the following: “that is not located in
 5 a State that is a participating State under the America’s
 6 Health Care Option Act”.

7 **SEC. 814. MORATORIUM ON DESIGNATION OF NEW LONG-**
 8 **TERM HOSPITALS.**

9 Effective October 1, 1994, notwithstanding clause
 10 (iv) of section 1886(d)(1)(B) of the Social Security Act
 11 (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an av-
 12 erage inpatient length of stay (as determined by the Sec-
 13 retary of Health and Human Services) of greater than 25
 14 days shall not be treated as a hospital described in such
 15 clause for purposes of such title unless such hospital was
 16 treated as a hospital described in such clause for purposes
 17 of such title as of the date of the enactment of this Act.

18 **SEC. 815. REDUCTION IN ADJUSTMENT FOR INDIRECT MED-**
 19 **ICAL EDUCATION.**

20 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42
 21 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as fol-
 22 lows:

23 “(ii) For purposes of clause (i)(II), the indirect
 24 teaching adjustment factor is equal to $c * (((1+r)$
 25 $\text{to the } n\text{th power}) - 1)$, where ‘r’ is the ratio of the

1 hospital's full-time equivalent interns and residents
 2 to beds and 'n' equals .405. For discharges occur-
 3 ring on or after—

4 “(I) May 1, 1986, and before October 1,
 5 1995, 'c' is equal to 1.89, and

6 “(II) October 1, 1995, 'c' is equal to
 7 1.65.”.

8 (b) NO RESTANDARDIZATION OF PAYMENT
 9 AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42
 10 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking “of
 11 1985” and inserting “of 1985, but not taking into account
 12 the amendments made by section 816(a) of the America's
 13 Health Care Option Act”.

14 **SEC. 816. REDUCTION IN ROUTINE SERVICE COST LIMITS**
 15 **FOR SKILLED NURSING FACILITIES.**

16 (a) PAYMENTS BASED ON COST LIMITS.—Section
 17 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking
 18 “112 percent” each place it appears and inserting “106
 19 percent (adjusted by such amount as the Secretary deter-
 20 mines to be necessary to preserve the savings resulting
 21 from the enactment of section 13503(a)(1) of the Omni-
 22 bus Budget Reconciliation Act of 1993)”.

23 (b) EFFECTIVE DATE.—The amendments made by
 24 subsection (a) shall apply to cost reporting periods begin-
 25 ning on or after October 1, 1995.

1 **PART III—PROVISIONS RELATING TO PART B**

2 **SEC. 821. UPDATES FOR PHYSICIANS' SERVICES.**

3 Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is
4 amended—

5 (1) in subparagraph (A), by inserting after
6 “subparagraph (B)” the following: “and, in the case
7 of 1995, specified in subparagraph (C)”;

8 (2) by redesignating subparagraph (C) as sub-
9 paragraph (D); and

10 (3) by inserting after subparagraph (B) the fol-
11 lowing new subparagraph:

12 “(C) SPECIAL PROVISION FOR 1995.—For
13 purposes of subparagraph (A), the conversion
14 factor specified in this subparagraph for 1995
15 is in the case of physicians’ services (not in-
16 cluded in the category of primary care services
17 (as defined for purposes of subsection (j)(1))),
18 the conversion factor established under this
19 subsection for 1994 reduced by 3 percent and
20 adjusted by the update established under para-
21 graph (3) for 1995.”.

1 **SEC. 822. SUBSTITUTION OF REAL GDP TO ADJUST FOR**
 2 **VOLUME AND INTENSITY; REPEAL OF RE-**
 3 **STRICTION ON MAXIMUM REDUCTION PER-**
 4 **MITTED IN DEFAULT UPDATE.**

5 (a) USE OF REAL GDP TO ADJUST FOR VOLUME
 6 AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C.
 7 1395w-4(f)(2)(A)(iii)) is amended to read as follows:

8 “(iii) 1 plus the average per capita
 9 growth in the real gross domestic product
 10 (divided by 100) for the 5-fiscal-year pe-
 11 riod ending with the previous fiscal year
 12 (increased by 1.5 percentage points for the
 13 category of services consisting of primary
 14 care services), and”.

15 (b) REPEAL OF RESTRICTION ON MAXIMUM REDUC-
 16 TION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w-
 17 4(d)(3)(B)(ii)) is amended—

18 (1) in the heading, by inserting “IN CERTAIN
 19 YEARS” after “ADJUSTMENT”;

20 (2) in the matter preceding subclause (I), by
 21 striking “for a year”;

22 (3) in subclause (I), by adding “and” at the
 23 end;

24 (4) in subclause (II), by striking “, and” and
 25 inserting a period; and

26 (5) by striking subclause (III).

1 (c) REPEAL OF PERFORMANCE STANDARD FAC-
2 TOR.—

3 (1) IN GENERAL.—Section 1848(f)(2) is
4 amended by striking subparagraph (B) and redesign-
5 ating subparagraph (C) as subparagraph (B).

6 (2) CONFORMING AMENDMENT.—Section
7 1848(f)(2)(A) is amended in the matter following
8 clause (iv) by striking “1, multiplied by 100” and all
9 that follows through “subparagraph (B))” and in-
10 serting “1 and multiplied by 100”.

11 (d) EFFECTIVE DATE.—

12 (1) VOLUME PERFORMANCE STANDARDS.—The
13 amendments made by subsections (a) and (c) shall
14 apply with respect to volume performance standards
15 established beginning with fiscal year 1995.

16 (2) REPEAL OF RESTRICTION ON MAXIMUM RE-
17 Duction.—The amendments made by subsection (b)
18 shall apply to services furnished on or after January
19 1, 1997.

20 **SEC. 823. ESTABLISHMENT OF CUMULATIVE EXPENDITURE**
21 **GOALS FOR PHYSICIAN SERVICES.**

22 (a) USE OF CUMULATIVE PERFORMANCE STAND-
23 ARD.—Section 1848(f)(2) (42 U.S.C. 1395w-4(f)(2)) is
24 amended—

25 (1) in subparagraph (A)—

1 (A) in the heading, by striking “IN GEN-
2 ERAL” and inserting “FISCAL YEARS 1991
3 THROUGH 1994.—”,

4 (B) in the matter preceding clause (i), by
5 striking “a fiscal year (beginning with fiscal
6 year 1991)” and inserting “fiscal years 1991,
7 1992, 1993, and 1994”, and

8 (C) in the matter following clause (iv), by
9 striking “subparagraph (B)” and inserting
10 “subparagraph (C)”;

11 (2) in subparagraph (B), by striking “subpara-
12 graph (A)” and inserting “subparagraphs (A) and
13 (B)”;

14 (3) by redesignating subparagraphs (B) and
15 (C) as subparagraphs (C) and (D); and

16 (4) by inserting after subparagraph (A) the fol-
17 lowing new subparagraph:

18 “(B) FISCAL YEARS BEGINNING WITH FIS-
19 CAL YEAR 1995.—Unless Congress otherwise
20 provides, the performance standard rate of in-
21 crease, for all physicians’ services and for each
22 category of physicians’ services, for a fiscal year
23 beginning with fiscal year 1995 shall be equal
24 to the performance standard rate of increase

determined under this paragraph for the previous fiscal year, increased by the product of—

“(i) 1 plus the Secretary’s estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians’ services or for the category of physicians’ services, respectively, under this part for portions of calendar years included in the fiscal year involved,

“(ii) 1 plus the Secretary’s estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

“(iii) 1 plus the Secretary’s estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians’ services or of the category of physicians’ services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

1 “(iv) 1 plus the Secretary’s estimate
 2 of the percentage increase or decrease (di-
 3 vided by 100) in expenditures for all physi-
 4 cians’ services or of the category of physi-
 5 cians’ services, respectively, in the fiscal
 6 year (compared with the previous fiscal
 7 year) which are estimated to result from
 8 changes in law or regulations affecting the
 9 percentage increase described in clause (i)
 10 and which is not taken into account in the
 11 percentage increase described in clause (i),
 12 minus 1, multiplied by 100, and reduced by the
 13 performance standard factor (specified in sub-
 14 paragraph (C)).”.

15 (b) TREATMENT OF DEFAULT UPDATE.—

16 (1) IN GENERAL.—Section 1848(d)(3)(B) (42
 17 U.S.C. 1395w-4(d)(3)(B)) is amended—

18 (A) in clause (i)—

19 (i) in the heading, by striking “IN
 20 GENERAL” and inserting “1992 THROUGH
 21 1996”, and

22 (ii) by striking “for a year” and in-
 23 serting “for 1992, 1993, 1994, 1995, and
 24 1996”; and

1 (B) by adding after clause (ii) the follow-
2 ing new clause:

3 “(iii) YEARS BEGINNING WITH 1997.—

4 “(I) IN GENERAL.—The update
5 for a category of physicians’ services
6 for a year beginning with 1997 pro-
7 vided under subparagraph (A) shall be
8 increased or decreased by the same
9 percentage by which the cumulative
10 percentage increase in actual expendi-
11 tures for such category of physicians’
12 services for such year was less or
13 greater, respectively, than the per-
14 formance standard rate of increase
15 (established under subsection (f)) for
16 such category of services for such
17 year.

18 “(II) CUMULATIVE PERCENTAGE
19 INCREASE DEFINED.—In subclause
20 (I), the ‘cumulative percentage in-
21 crease in actual expenditures’ for a
22 year shall be equal to the product of
23 the adjusted increases for each year
24 beginning with 1995 up to and includ-
25 ing the year involved, minus 1 and

1 multiplied by 100. In the previous
 2 sentence, the ‘adjusted increase’ for a
 3 year is equal to 1 plus the percentage
 4 increase in actual expenditures for the
 5 year.”.

6 (2) CONFORMING AMENDMENT.—Section
 7 1848(d)(3)(A)(i) (42 U.S.C. 1395w-4(d)(3)(A)(i)) is
 8 amended by striking “subparagraph (B)” and insert-
 9 ing “subparagraphs (B) and (C)”.

10 **SEC. 824. ESTABLISHMENT OF HOSPITAL OUTPATIENT PRO-**
 11 **SPECTIVE PAYMENT SYSTEM FOR HOSPITAL**
 12 **OUTPATIENT DEPARTMENTS.**

13 (a) IN GENERAL.—Section 1833(a)(2)(B) of the So-
 14 cial Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended
 15 by striking “section 1886)—” and all that follows and in-
 16 serting the following: “section 1886), an amount equal to
 17 a prospectively determined payment rate established by
 18 the Secretary that provides for payments for such items
 19 and services to be based upon a national rate adjusted
 20 to take into account the relative costs of furnishing such
 21 items and services in various geographic areas, except that
 22 for items and services furnished during cost reporting pe-
 23 riods (or portions thereof) beginning on or after January
 24 1, 1995, such amount shall not exceed 90 percent of the
 25 amount that would otherwise have been determined under

1 this subparagraph had the amendment made by section
2 824(a) of the America's Health Care Option Act had not
3 taken effect;”.

4 (b) ESTABLISHMENT OF PROSPECTIVE PAYMENT
5 SYSTEM.—Not later than January 1, 1995, the Secretary
6 of Health and Human Services shall establish the prospec-
7 tive payment system for hospital outpatient services nec-
8 essary to carry out section 1833(a)(2)(B) of the Social
9 Security Act (as amended by subsection (a)). Such pro-
10 spective payment system shall provide that an individual
11 have a cost-sharing requirement of 20 percent of the al-
12 lowable amount on which the prospectively determined
13 rate for such service is based.

14 (c) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply to items and services furnished
16 on or after January 1, 1995.

17 **SEC. 825. GENERAL PART B PREMIUM.**

18 Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

19 (1) in paragraph (1)(A), by striking “and prior
20 to January 1999”; and

21 (2) in paragraph (2), by striking “prior to Jan-
22 uary 1998”.

1 **PART IV—PROVISIONS RELATED TO PARTS A**
2 **AND B**

3 **SEC. 831. MEDICARE SECONDARY PAYER CHANGES.**

4 (a) EXTENSION OF DATA MATCH.—

5 (1) Section 1862(b)(5)(C) (42 U.S.C.
6 1395y(b)(5)(C)) is amended by striking clause (iii).

7 (2) Section 6103(l)(12) of the Internal Revenue
8 Code of 1986 is amended by striking subparagraph
9 (F).

10 (b) REPEAL OF SUNSET ON APPLICATION TO DIS-
11 ABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN
12 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C.
13 1395y(b)(1)(B)(iii)) is amended—

14 (1) in the heading, by striking “SUNSET” and
15 inserting “EFFECTIVE DATE”; and

16 (2) by striking “, and before October 1, 1998”.

17 (c) EXTENSION OF PERIOD FOR END STAGE RENAL
18 DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42
19 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence
20 by striking “and on or before October 1, 1998,”.

21 **SEC. 832. INCREASE IN MEDICARE SECONDARY PAYER COV-**
22 **ERAGE FOR END STAGE RENAL DISEASE**
23 **SERVICES TO 24 MONTHS.**

24 (a) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C.
25 1395y(b)(1)(C)), as amended by section 831(c), is amend-
26 ed by striking the last sentence and inserting: “Effective

1 for items and services furnished on or after January 1,
 2 1996 (with respect to periods beginning on or after July
 3 1, 1994), this subparagraph shall be applied by substitut-
 4 ing ‘24-month’ for ‘12-month’ each place it appears.’.

5 (b) EFFECTIVE DATE.—The amendment made by
 6 subsection (a) shall apply to items and services provided
 7 on or after January 1, 1996.

8 **SEC. 833. REDUCTION IN ROUTINE COST LIMITS FOR HOME**
 9 **HEALTH SERVICES.**

10 Section 1861(v)(1)(L)(i) (42 U.S.C.
 11 1395x(v)(1)(L)(i)) is amended—

12 (1) in subclause (II), by striking “or” at the
 13 end;

14 (2) in subclause (III), by striking “112 per-
 15 cent,” and inserting “and before July 1, 1996, 112
 16 percent, or”; and

17 (3) by inserting after subclause (III) the follow-
 18 ing new subclause:

19 “(IV) July 1, 1996, 106 percent (adjusted by
 20 such amount as the Secretary determines to be nec-
 21 essary to preserve the savings resulting from the en-
 22 actment of section 13564(a)(1) of the Omnibus
 23 Budget Reconciliation Act of 1993),”.

1 **Subtitle B—Medicaid Program**

2 **PART I—COORDINATION OF THE MEDICAID PRO-**
3 **GRAM WITH REFORMED HEALTH CARE SYS-**
4 **TEM**

5 **SEC. 851. STATE PLAN REQUIREMENT REGARDING ELIGI-**
6 **BILITY FOR MEDICAL ASSISTANCE.**

7 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
8 1369a(a)), as amended by sections 121 and 201(a), is
9 amended—

10 (1) by striking “and” at the end of paragraph
11 (63);

12 (2) by striking the period at the end of para-
13 graph (64) and inserting “; and ”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(65) provide that the State will continue to
17 make eligible for medical assistance under section
18 1902(a)(10) any class or category of individuals eli-
19 gible for medical assistance under such section as of
20 the date of the enactment of the America’s Health
21 Care Option Act.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall be effective with respect to calendar
24 quarters beginning on or after the date of the enactment
25 of this Act.

1 **SEC. 852. CAP ON PAYMENTS MADE FOR CERTAIN ACUTE**
2 **MEDICAL SERVICES FURNISHED UNDER THE**
3 **MEDICAID PROGRAM.**

4 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et
5 seq.) is amended by redesignating section 1931 as section
6 1932 and by inserting after section 1930 the following new
7 section:

8 “CAP ON PAYMENTS MADE FOR CERTAIN ACUTE MEDICAL
9 SERVICES

10 “SEC. 1931. (a) FEDERAL CAP.—

11 “(1) IN GENERAL.—Notwithstanding any provi-
12 sion of this part, the amount of any payment to a
13 State under section 1903(a)(1) with respect to ex-
14 penditures made by a State for furnishing acute
15 medical services (as defined in subsection (c)(1)) of
16 the type included in the FedMed benefits package
17 (as described in section 21115(b)) to integration eli-
18 gible individuals (as defined in subsection (c)(2)) in
19 any calendar quarter shall not be in excess of the
20 amount determined under paragraph (2) for the
21 quarter.

22 “(2) AMOUNT DETERMINED.—The amount de-
23 termined under this paragraph for a quarter is an
24 amount equal to $\frac{1}{4}$ of the product of—

25 “(A) the State’s Federal medical assist-
26 ance percentage (as defined in section 1905(b))

1 of the weighted average maximum premium
2 subsidy amount (as defined in subsection
3 (c)(4)) for the State for the year; multiplied by

4 “(B) the average number of integration eli-
5 gible individuals receiving medical assistance
6 under the State plan consisting of acute medi-
7 cal services of the type included in the FedMed
8 benefits package in any month in the quarter.

9 “(b) STATE CAP.—

10 “(1) IN GENERAL.—Notwithstanding any provi-
11 sion of this part, a State shall not be obligated to
12 expend an amount in excess of the amount deter-
13 mined under paragraph (2) in any calendar quarter
14 for furnishing acute medical services of the type in-
15 cluded in the FedMed benefits package to integra-
16 tion eligible individuals.

17 “(2) AMOUNT DETERMINED.—The amount de-
18 termined under this paragraph for a quarter is an
19 amount equal to $\frac{1}{4}$ of the product of—

20 “(A) the State matching percentage (as de-
21 fined in subsection (a)(3)) of weighted average
22 maximum premium subsidy amount for the
23 State for the year; multiplied by

24 “(B) the average number of integration eli-
25 gible individuals receiving medical assistance

1 under the State plan consisting of acute medi-
2 cal services of the type included in the FedMed
3 benefits package in any month in the quarter.

4 “(c) DEFINITIONS.—

5 “(1) ACUTE MEDICAL SERVICES.—The term
6 ‘acute medical services’ means items and services de-
7 scribed in section 1905(a) other than the following:

8 “(A) Nursing facility services (as defined
9 in section 1905(f)).

10 “(B) Intermediate care facility for the
11 mentally retarded services (as defined in section
12 1905(d)).

13 “(C) Personal care services (as described
14 in section 1905(a)(24)).

15 “(D) Private duty nursing services (as re-
16 ferred to in section 1905(a)(8)).

17 “(E) Home or community-based services
18 furnished under a waiver granted under sub-
19 section (c), (d), or (e) of section 1915.

20 “(F) Home and community care furnished
21 to functionally disabled elderly individuals
22 under section 1929.

23 “(G) Community supported living arrange-
24 ments services under section 1930.

1 “(H) Case-management services (as de-
2 scribed in section 1915(g)(2)).

3 “(I) Home health care services (as referred
4 to in section 1905(a)(7)), clinic services, and re-
5 habilitation services that are furnished to an in-
6 dividual who has a condition or disability that
7 qualifies the individual to receive any of the
8 services described in a previous subparagraph.

9 “(J) Services furnished in an institution
10 for mental diseases (as defined in section
11 1905(i)).

12 “(2) INTEGRATION ELIGIBLE INDIVIDUAL.—
13 The term ‘integration eligible individual’ means, with
14 respect to any calendar quarter, an individual who
15 would not be eligible for medical assistance consist-
16 ing of acute medical services of the type included in
17 the FedMed benefits package if the provisions of
18 section 1932(a) were in effect during such quarter.

19 “(3) STATE MATCHING PERCENTAGE.—The
20 term ‘State matching percentage’ means, with re-
21 spect to a State, the amount (expressed as a per-
22 centage) equal to 1 minus the State’s Federal medi-
23 cal assistance percentage.

24 “(4) WEIGHTED AVERAGE MAXIMUM PREMIUM
25 SUBSIDY AMOUNT.—

1 “(A) IN GENERAL.—The term ‘weighted
2 average maximum premium subsidy amount’
3 for a State for a year means an amount equal
4 to—

5 “(i) the sum of—

6 “(I) the amount determined
7 under subparagraph (B) for each
8 community-rating area in the State;
9 multiplied by

10 “(II) the number of individuals
11 in such community rating area; di-
12 vided by

13 “(ii) the total number of individuals in
14 the State.

15 “(B) WEIGHTED AVERAGE MAXIMUM SUB-
16 SIDY AMOUNT IN A COMMUNITY-RATING
17 AREA.—The weighted average maximum sub-
18 sidy amount in a community-rating area is an
19 amount equal to—

20 “(i) the sum of—

21 “(I) the weighted average age ad-
22 justed maximum subsidy amount for
23 an enrollment class (as determined
24 under subparagraph (C)) in the com-
25 munity-rating area; multiplied by

1 “(II) the number of individuals
 2 in the enrollment class in the commu-
 3 nity-rating area; divided by

4 “(ii) the total number of individuals in
 5 the community-rating area.

6 “(C) WEIGHTED AVERAGE AGE ADJUSTED
 7 MAXIMUM SUBSIDY AMOUNT FOR AN ENROLL-
 8 MENT CLASS.—The weighted average age ad-
 9 justed maximum subsidy amount for an enroll-
 10 ment class is an amount equal to—

11 “(i) the sum of—

12 “(I) the age adjusted maximum
 13 subsidy amount determined under sec-
 14 tion 1952(b)(2)) for each category of
 15 primary insurer in the enrollment
 16 class; multiplied by

17 “(II) the number of individuals
 18 in each category; divided by

19 “(ii) the total number of individuals in
 20 all such categories.”.

21 (b) EFFECTIVE DATE.—The amendment made by
 22 subsection (a) shall be effective with respect to calendar
 23 quarters beginning on or after January 1, 1997.

1 **SEC. 853. INTEGRATION OF CERTAIN MEDICAID ELIGIBLES**
 2 **INTO REFORMED HEALTH CARE SYSTEM**
 3 **THROUGH STATE PREMIUM ASSISTANCE**
 4 **PROGRAM.**

5 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et
 6 seq.), as amended by section 852, is amended by redesignig-
 7 nating section 1932 as section 1933 and by inserting after
 8 section 1931 the following new section:

9 “INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO
 10 REFORMED HEALTH CARE SYSTEM

11 “SEC. 1932. (a) IN GENERAL.—

12 “(1) REQUIREMENT ON STATES.—With respect
 13 to calendar quarters beginning on or after January
 14 1, 2000, a State with a State plan under this part—

15 “(A) shall not furnish medical assistance
 16 consisting of acute medical services described in
 17 section 1931(b)(1) to any individuals not de-
 18 scribed in subsection (b) who are otherwise eli-
 19 gible for medical assistance under the plan; and

20 “(B) shall integrate such individuals into
 21 the State’s premium assistance program under
 22 part B.

23 “(2) STATE OPTION.—

24 “(A) IN GENERAL.—For 1997, 1998, and
 25 1999, a State may elect to integrate individuals
 26 into the State’s premium assistance program

1 under part B as described in paragraph (1) if
 2 the State notifies the Secretary of such election
 3 not later than October 1 of the year preceding
 4 the year the State intends to begin such inte-
 5 gration.

6 “(B) STATES FURNISHING SERVICES
 7 UNDER A WAIVER.—If a State making an elec-
 8 tion under subparagraph (A) is furnishing med-
 9 ical assistance consisting of acute medical serv-
 10 ices described in section 1931(b)(1) under a
 11 waiver under section 1115 granted on or before
 12 December 31, 1996, to individuals who would
 13 otherwise be integrated into the State’s pre-
 14 mium assistance program, such State may con-
 15 tinue to furnish such services to such individ-
 16 uals until the earlier of the termination of the
 17 waiver by the State or the Secretary or January
 18 1, 2000.

19 “(b) INDIVIDUALS DESCRIBED.—The individuals de-
 20 scribed in this subsection are—

21 “(1) SSI-eligible individuals (as defined in sec-
 22 tion 1933(d)(2));

23 “(2) individuals who are eligible for benefits
 24 under part A of title XVIII; and

1 “(3) certain aliens with respect to whom emer-
2 gency services are furnished under section
3 1903(v)(2).

4 “(c) STATE MAINTENANCE OF EFFORT.—

5 “(1) IN GENERAL.—

6 “(A) REDUCTION IN QUARTERLY PAY-
7 MENTS.—For any calendar quarter in an inte-
8 gration year (as defined in subparagraph (B)),
9 the amount otherwise payable to a State under
10 section 1903 for the quarter shall be reduced by
11 the State maintenance of effort amount for the
12 quarter determined under paragraph (2).

13 “(B) INTEGRATION YEAR.—For purposes
14 of this paragraph, the term ‘integration year’
15 means the first year that the State integrates
16 individuals into the State’s premium assistance
17 program under part B and any succeeding year.

18 “(2) MAINTENANCE OF EFFORT AMOUNT.—

19 “(A) IN GENERAL.—The maintenance of
20 effort amount for a State for a calendar quarter
21 in an integration year shall be equal to 25 per-
22 cent of the State’s base payment amount (de-
23 termined under subparagraph (B)) updated by
24 the percentage change in the inflation index de-
25 scribed in subparagraph (C)(i) and the State

1 population index described in subparagraph
2 (C)(ii) during the period beginning on January
3 1 of the first integration year and ending on
4 December 31 of the applicable integration year
5 (as determined by the Secretary).

6 “(B) STATE BASE PAYMENT AMOUNT.—

7 The base payment amount for a State for an
8 integration year shall be an amount, as deter-
9 mined by the Secretary, equal to the total ex-
10 penditures from State funds made under the
11 State plan during the year preceding the first
12 integration year with respect to medical assist-
13 ance consisting of acute medical services of the
14 type included in the FedMed benefits package
15 (as described in section 21115(b)) furnished to
16 individuals who would not have received such
17 assistance if the provisions of subsection (a)
18 were in effect during such year.

19 “(C) INDEXES DESCRIBED.—

20 “(i) INFLATION INDEX.—The Sec-
21 retary shall establish an index which meas-
22 ures the percentage change in the weighted
23 average maximum premium subsidy
24 amount (as defined in section 1931(c)(4))
25 for the State from year to year.

1 “(ii) STATE POPULATION INDEX.—

2 The Secretary shall establish a State popu-
3 lation index which measures the change in
4 the number of individuals residing in a
5 State from year to year.”

6 (b) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-
7 tion 1903(i) (42 U.S.C. 1396b(i)) is amended—

8 (1) by striking “or” at the end of paragraph
9 (14),

10 (2) by striking the period at the end of para-
11 graph (15) and inserting “; or”, and

12 (3) by inserting after paragraph (15) the fol-
13 lowing new paragraph:

14 “(16) with respect any medical assistance con-
15 sisting of acute medical services described in section
16 1931(b) furnished to individuals who are not de-
17 scribed in section 1932(b).”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall be effective with respect calendar quar-
20 ters beginning on or after January 1, 1997.

21 **SEC. 854. STATE PROGRAMS FOR PROVIDING SUPPLE-**
22 **MENTAL BENEFITS.**

23 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
24 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),

1 as amended by sections 121, 201(a), and 851, is amend-
2 ed—

3 (1) by striking “and” at the end of paragraph
4 (64);

5 (2) by striking the period at the end of para-
6 graph (65) and inserting “; and”; and

7 (3) by adding at the end the following new
8 paragraph:

9 “(66) provide for a State program furnishing
10 supplemental benefits in accordance with part C.”.

11 (b) STATE PROGRAMS FOR SUPPLEMENTAL BENE-
12 FITS.—Title XIX (42 U.S.C. 1396 et seq.), as amended
13 by section 121, is amended by adding at the end the fol-
14 lowing new part:

15 **“PART C—STATE PROGRAMS FOR**
16 **SUPPLEMENTAL BENEFITS**

17 **“SEC. 1961. REQUIREMENT TO OPERATE STATE PROGRAM.**

18 “(a) IN GENERAL.—A State with a State plan ap-
19 proved under part A shall have in effect a program for
20 furnishing supplemental benefits (as defined in section
21 1962(c)) in accordance with this part in calendar years
22 beginning after 1996.

23 “(b) DESIGNATION OF STATE AGENCY.—A State
24 may designate any appropriate State agency to administer
25 the program under this part.

1 **“SEC. 1962. PROGRAM DESCRIBED.**

2 “(a) IN GENERAL.—A State program under this part
3 shall furnish supplemental benefits to such classes and
4 categories of the individuals eligible for premium assist-
5 ance under part B as determined appropriate by the State.

6 “(b) PRIORITIES.—A State may give priority to chil-
7 dren, pregnant women, and individuals residing in medi-
8 cally underserved areas in furnishing services under this
9 part.

10 “(c) SUPPLEMENTAL BENEFITS DEFINED.—The
11 term ‘supplemental benefits’ means the acute medical
12 services described in section 1931(b) that—

13 “(1) were furnished under the State plan in the
14 year preceding the first year that the State inte-
15 grates individuals into the State’s premium assist-
16 ance program under part B in accordance with sec-
17 tion 1932(a); and

18 “(2) are not included in the items and services
19 provided under the FedMed benefits package (as de-
20 scribed in 21115(b)).

21 **“SEC. 1963. PAYMENTS TO STATES.**

22 “From its allotment under section 1964(b), the Sec-
23 retary shall pay to each State for each quarter beginning
24 with the quarter commencing January 1, 1997, an amount
25 equal to—

1 “(1) an amount equal to the State’s Federal
 2 medical assistance percentage (as defined in section
 3 1905(b)) of the amount demonstrated by State
 4 claims to have been expended during the quarter for
 5 furnishing services to eligible individuals under this
 6 part; plus

7 “(2) an amount equal to 50 percent of the re-
 8 mainder of the amounts expended during the quar-
 9 ter as found necessary by the Secretary for the prop-
 10 er and efficient administration of the State program.

11 **“SEC. 1964. FUNDING.**

12 “(a) IN GENERAL.—The total amount of Federal
 13 funds available for State programs under this part for
 14 each fiscal year is—

15 “(1) for fiscal year 1997, \$12,000,000,000; and

16 “(2) for succeeding fiscal years, the amount de-
 17 termined under this subsection for the preceding fis-
 18 cal year updated by the estimated percentage change
 19 in the inflation index described in section
 20 1932(c)(2)(C)(i) and the State population index de-
 21 scribed in section 1932(c)(2)(C)(ii).

22 “(b) ALLOTMENTS TO STATES.—

23 “(1) IN GENERAL.—The Secretary shall allot
 24 the amounts available under subsection (a) for the
 25 fiscal year to the States in accordance with an allo-

1 cation formula developed by the Secretary which
2 takes into account—

3 “(A) the percentage of all individuals with
4 incomes at or below 150 percent of the official
5 poverty line (as defined in section 1957(6)) in
6 all States that reside in a particular State; and

7 “(B) a State’s matching percentage (as de-
8 fined in section 1932(c)(4)(B)).

9 “(2) REALLOCATIONS.—Any amounts allotted
10 to States under this subsection for a year that are
11 not expended in such year shall remain available for
12 State programs under this part and may be reallo-
13 cated to States as the Secretary determines appro-
14 priate.

15 “(c) STATE ENTITLEMENT.—This part constitutes
16 budget authority in advance of appropriations Acts, and
17 represents the obligation of the Federal Government to
18 provide for the payment to States of amounts described
19 in subsection (a).”.

20 (c) CONFORMING AMENDMENTS.—Title XIX (42
21 U.S.C. 1396 et seq.), as amended by section 121, is
22 amended by striking the title and inserting the following:

1 **“TITLE XIX—MEDICAL ASSIST-**
2 **ANCE PROGRAMS, STATE**
3 **PROGRAMS FOR PREMIUM**
4 **ASSISTANCE, AND STATE**
5 **PROGRAMS FOR SUPPLE-**
6 **MENTAL BENEFITS”.**

7 **SEC. 855. OPTIONAL COVERAGE UNDER CERTIFIED**
8 **HEALTH PLANS OF SSI-ELIGIBLE INDIVID-**
9 **UALS.**

10 (a) STATE OPTION.—Section 1902(a) (42 U.S.C.
11 1396a(a)), as amended by sections 121, 201(a), 851, and
12 854, is amended—

13 (1) by striking “and” at the end of paragraph
14 (65);

15 (2) by striking the period at the end of para-
16 graph (66) and inserting “; and”; and

17 (3) by adding at the end the following new
18 paragraph:

19 “(67) at the option of the State, provide that
20 a SSI-eligible individual (as defined in section
21 1933(d)) has the option to receive medical assistance
22 consisting of the items or services covered under the
23 FedMed benefits package (as described in section
24 21115(b)) through enrollment with a certified health
25 plan (as defined in 21003(b)) providing such pack-

1 age instead of through enrollment in the State plan,
2 in accordance with the requirements of section
3 1933.”.

4 (b) REQUIREMENTS DESCRIBED.—Title XIX (42
5 U.S.C. 1396 et seq.) is amended by redesignating section
6 1933 as section 1934 and by inserting after section 1932
7 the following new section:

8 “REQUIREMENTS FOR STATES PROVIDING OPTIONAL COV-
9 ERAGE UNDER CERTIFIED HEALTH PLANS TO SSI-
10 ELIGIBLE INDIVIDUALS

11 “SEC. 1933. (a) IN GENERAL.—For purposes of sec-
12 tion 1902(a)(67), a State meets the requirements of this
13 section with respect to SSI-eligible individuals if the State
14 meets the following requirements:

15 “(1) CHOICE OF PLANS.—The State must offer
16 individuals a choice of a certified health plans under
17 such section, except that nothing in this paragraph
18 may be construed to waive any limits on the capacity
19 of a certified health plan applicable under title XXI.

20 “(2) INFORMED CHOICE.—The State shall en-
21 sure that each SSI-eligible individual is provided suf-
22 ficient information to make an informed choice
23 about enrolling in a certified health plan under such
24 section and selecting such a plan.

25 “(3) PAYMENTS TO CERTIFIED HEALTH PLANS
26 BY STATES.—The State shall make all necessary

1 payments of premiums, copayments, and deductibles
2 applicable under a certified health plan on behalf of
3 a SSI-eligible individual who enrolls in a certified
4 health plan under such section.

5 “(b) TREATMENT OF PAYMENTS AS MEDICAL AS-
6 SISTANCE.—For purposes of determining the amount of
7 Federal financial participation for a State under section
8 1903 in a quarter, any payments made by a State under
9 subsection (a)(3) shall be treated as expenditures for med-
10 ical assistance under the State plan for such quarter.

11 “(c) LIMITATION ON NUMBER OF INDIVIDUALS PER-
12 MITTED TO MAKE ELECTION.—

13 “(1) IN GENERAL.—

14 “(A) LIMITATION.—The number of SSI-el-
15 igible individuals electing to enroll in a certified
16 health plan under section 1902(a)(67) in a
17 State during a year may not exceed the applica-
18 ble percentage determined under subparagraph
19 (B) of the Secretary’s estimate of the number
20 of such individuals in the State who are eligible
21 to enroll in certified health plans under such
22 section during the year.

23 “(B) APPLICABLE PERCENTAGE DE-
24 SCRIBED.—The ‘applicable percentage’ deter-

1 mined under this subparagraph with respect to
2 a State for a year—

3 “(i) for each of the first 3 years for
4 which the State exercises the option de-
5 scribed in such section, 15 percent; and

6 “(ii) for each succeeding year for
7 which the State exercises such option, the
8 applicable percentage under this subpara-
9 graph for the preceding year, increased by
10 10 percent.

11 “(2) WAIVER OF LIMITATION.—The limit on
12 the number of individuals provided in paragraph (1)
13 may be waived by the Secretary with respect to a
14 State if the Secretary determines that such a waiver
15 is appropriate.

16 “(d) DEFINITIONS.—

17 “(1) CERTIFIED HEALTH PLAN.—The term
18 ‘certified health plan’ means a certified health plan
19 (as defined in section 21003(b)) that provides a
20 FedMed benefits package (as described in section
21 21115(b)).

22 “(2) SSI-ELIGIBLE INDIVIDUAL.—The term
23 ‘SSI-eligible individual’ means an individual who is
24 eligible for medical assistance under the State plan
25 and—

1 “(A) with respect to whom supplemental
2 security income benefits are being paid under
3 title XVI,

4 “(B) who is receiving a supplementary
5 payment under section 1616 or under section
6 212 of Public Law 93–66, or

7 “(C) who is receiving monthly benefits
8 under section 1619(a) (whether or not pursuant
9 to section 1616(c)(3)).”.

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall be effective with respect to calendar
12 quarters beginning on or after January 1, 1997.

13 **PART II—STATE ELIGIBILITY TO CONTRACT FOR**
14 **COORDINATED CARE SERVICES**

15 **SEC. 861. MODIFICATION OF FEDERAL REQUIREMENTS TO**
16 **ALLOW STATES MORE FLEXIBILITY IN CON-**
17 **TRACTING FOR COORDINATED CARE SERV-**
18 **ICES UNDER MEDICAID.**

19 (a) IN GENERAL.—

20 (1) PAYMENT PROVISIONS.—Section 1903(m)
21 (42 U.S.C. 1396b(m)) is amended to read as follows:

22 “(m)(1) No payment shall be made under this title
23 to a State with respect to expenditures incurred by such
24 State for payment to an entity which is at risk (as defined
25 in section 1931(a)(4)) for services provided by such entity

1 to individuals eligible for medical assistance under the
 2 State plan under this title, unless the entity is a risk con-
 3 tracting entity (as defined in section 1931(a)(3)) and the
 4 State and such entity comply with the applicable provi-
 5 sions of section 1931.

6 “(2) No payment shall be made under this title to
 7 a State with respect to expenditures incurred by such
 8 State for payment for services provided to an individual
 9 eligible for medical assistance under the State plan under
 10 this title if such payment by the State is contingent upon
 11 the individual receiving such services from a specified
 12 health care provider or subject to the approval of a speci-
 13 fied health care provider, unless the entity receiving pay-
 14 ment is a primary care case management entity (as de-
 15 fined in section 1931(a)(2)) and the State and such entity
 16 comply with the applicable provisions of section 1931.”.

17 (2) REQUIREMENTS FOR COORDINATED CARE
 18 SERVICES.—Title XIX (42 U.S.C. 1396 et seq.) is
 19 amended by adding at the end the following new sec-
 20 tion:

21 “REQUIREMENTS FOR COORDINATED CARE SERVICES

22 “SEC. 1931. (a) DEFINITIONS.—For purposes of this
 23 title—

24 “(1) PRIMARY CARE CASE MANAGEMENT PRO-
 25 GRAM.—The term ‘primary care case management
 26 program’ means a program operated by a State

1 agency under which such State agency enters into
2 contracts with primary care case management enti-
3 ties for the provision of health care items and serv-
4 ices which are specified in such contracts and the
5 provision of case management services to individuals
6 who are—

7 “(A) eligible for medical assistance under
8 the State plan,

9 “(B) enrolled with such primary care case
10 management entities, and

11 “(C) entitled to receive such specified
12 health care items and services and case man-
13 agement services only as approved and ar-
14 ranged for, or provided, by such entities.

15 “(2) PRIMARY CARE CASE MANAGEMENT EN-
16 TITY.—The term ‘primary care case management
17 entity’ means a health care provider which—

18 “(A) must be a physician, group of physi-
19 cians, a Federally qualified health center, a
20 rural health clinic, or an entity employing or
21 having other arrangements with physicians op-
22 erating under a contract with a State to provide
23 services under a primary care case management
24 program,

1 “(B) receives payment on a fee for service
2 basis (or, in the case of a Federally qualified
3 health center or a rural health clinic, on a rea-
4 sonable cost per encounter basis) for the provi-
5 sion of health care items and services specified
6 in such contract to enrolled individuals,

7 “(C) receives an additional fixed fee per
8 enrollee for a period specified in such contract
9 for providing case management services (includ-
10 ing approving and arranging for the provision
11 of health care items and services specified in
12 such contract on a referral basis) to enrolled in-
13 dividuals, and

14 “(D) is not an entity that is at risk (as de-
15 fined in paragraph (4)) for such case manage-
16 ment services.

17 “(3) RISK CONTRACTING ENTITY.—The term
18 ‘risk contracting entity’ means an entity, including a
19 certified health plan (as defined in section 21003(b))
20 that provides a FedMed benefits package (as de-
21 scribed in section 21115(b)), which has a contract
22 with the State agency (or a health insuring organi-
23 zation described in subsection (l)(2)) under which
24 the entity—

1 “(A) provides or arranges for the provision
2 of health care items or services which are speci-
3 fied in such contract to individuals eligible for
4 medical assistance under the State plan, and

5 “(B) is at risk (as defined in paragraph
6 (4)) for part or all of the cost of such items or
7 services furnished to individuals eligible for
8 medical assistance under such plan.

9 “(4) AT RISK.—The term ‘at risk’ means an
10 entity which—

11 “(A) has a contract with the State agency
12 under which such entity is paid a fixed amount
13 for providing or arranging for the provision of
14 health care items or services specified in such
15 contract to an individual eligible for medical as-
16 sistance under the State plan and enrolled with
17 such entity, regardless of whether such items or
18 services are furnished to such individual, and

19 “(B) is liable for all or part of the cost of
20 furnishing such items or services, regardless of
21 whether such cost exceeds such fixed payment.

22 “(5) FEDERALLY QUALIFIED HEALTH CEN-
23 TER.—The term ‘Federally qualified health center’
24 means a Federally qualified health center as defined
25 in section 1905(l)(2)(B).

1 “(6) RURAL HEALTH CLINIC.—The term ‘rural
2 health clinic’ means a rural health clinic as defined
3 in section 1905(l)(1).

4 “(b) GENERAL REQUIREMENTS FOR RISK CON-
5 TRACTING ENTITIES.—

6 “(1) ORGANIZATION.—A risk contracting entity
7 meets the requirements of this section only if such
8 entity—

9 “(A)(i) is a qualified health maintenance
10 organization as defined in section 1310(d) of
11 the Public Health Service Act, as determined by
12 the Secretary pursuant to section 1312 of such
13 Act; or

14 “(ii) is described in subparagraph (C), (D),
15 (E), (F), or (G) of subsection (e)(4);

16 “(B) is a Federally qualified health center
17 or a rural health clinic which has made ade-
18 quate provision against the risk of insolvency
19 (pursuant to the guidelines and regulations is-
20 sued by the Secretary under this section), and
21 ensures that individuals eligible for medical as-
22 sistance under the State plan are not held liable
23 for such entity’s debts in case of such entity’s
24 insolvency; or

1 “(C) is an entity which meets all applicable
2 State licensing requirements and has made ade-
3 quate provision against the risk of insolvency
4 (pursuant to the guidelines and regulations is-
5 sued by the Secretary under this section), and
6 ensures that individuals eligible for medical as-
7 sistance under the State plan are not held liable
8 for such entity’s debts in case of such entity’s
9 insolvency.

10 “(2) GUARANTEES OF ENROLLEE ACCESS.—A
11 risk contracting entity meets the requirements of
12 this section only if—

13 “(A) the geographic locations, hours of op-
14 eration, patient to staff ratios, and other rel-
15 evant characteristics of such entity are suffi-
16 cient to afford individuals eligible for medical
17 assistance under the State plan access to such
18 entities that is at least equivalent to the access
19 to health care providers that would be available
20 to such individuals if such individuals were not
21 enrolled with such entity;

22 “(B) such entity has reasonable and ade-
23 quate hours of operation, including 24-hour
24 availability of—

1 “(i)(I) treatment for an unforeseen ill-
2 ness, injury, or condition of an individual
3 eligible for medical assistance under the
4 State plan and enrolled with such entity;
5 or

6 “(II) referral to other health care pro-
7 viders for such treatment; and

8 “(ii) other information, as determined
9 by the Secretary or the State; and

10 “(C) such entity complies with such other
11 requirements relating to access to care as the
12 Secretary or the State may impose.

13 “(3) CONTRACT WITH STATE AGENCY.—A risk
14 contracting entity meets the requirements of this
15 section only if such entity has a written contract
16 with the State agency which provides—

17 “(A) that the entity will comply with all
18 applicable provisions of this section, that the
19 State has the right to penalize the entity for
20 failure to comply with such requirements and to
21 terminate the contract in accordance with sub-
22 section (i), and that the entity will be subject
23 to penalties imposed by the Secretary under
24 subsection (h) for failure to comply with such
25 requirements;

1 “(B) for a payment methodology based on
2 experience rating or another actuarially sound
3 methodology approved by the Secretary, which
4 guarantees (as demonstrated by such models or
5 formulas as the Secretary may approve) that—

6 “(i) payments to the entity under the
7 contract shall not exceed an amount equal
8 to 100 percent of the costs (which shall in-
9 clude administrative costs and which may
10 include costs for inpatient hospital services
11 that would have been incurred in the ab-
12 sence of such contract) that would have
13 been incurred by the State agency in the
14 absence of the contract; and

15 “(ii) the financial risk for inpatient
16 hospital services is limited to an extent es-
17 tablished by the State;

18 “(C) that the Secretary and the State (or
19 any person or organization designated by ei-
20 ther) shall have the right to audit and inspect
21 any books and records of the entity (and of any
22 subcontractor) that pertain—

23 “(i) to the ability of the entity (or a
24 subcontractor) to bear the risk of potential
25 financial losses; or

1 “(ii) to services performed or deter-
2 minations of amounts payable under the
3 contract;

4 “(D) that in the entity’s enrollment,
5 reenrollment, or disenrollment of individuals eli-
6 gible for medical assistance under the State
7 plan and eligible to enroll, reenroll, or disenroll
8 with the entity pursuant to the contract, the en-
9 tity will not discriminate among such individ-
10 uals on the basis of such individuals’ health sta-
11 tus or requirements for health care services;

12 “(E)(i) individuals eligible for medical as-
13 sistance under the State plan who have enrolled
14 with the entity are permitted to terminate such
15 enrollment without cause as of the beginning of
16 the first calendar month (or in the case of an
17 entity described in subsection (e)(4), as of the
18 beginning of the first enrollment period) follow-
19 ing a full calendar month after a request is
20 made for such termination;

21 “(ii) that when an individual has relocated
22 outside the entity’s service area, and the entity
23 has been notified of the relocation, services
24 (within reasonable limits) furnished by a health
25 care provider outside the service area will be re-

1 imbursed either by the entity or by the State
2 agency; and

3 “(iii) for written notification of each such
4 individual’s right to terminate enrollment,
5 which shall be provided at the time of such indi-
6 vidual’s enrollment;

7 “(F) in the case of services immediately re-
8 quired to treat an unforeseen illness, injury, or
9 condition, of an individual eligible for medical
10 assistance under the State plan and enrolled
11 with the entity—

12 “(i) that such services shall not be
13 subject to a preapproval requirement; and

14 “(ii) where such services are furnished
15 by a health care provider other than the
16 entity, for reimbursement of such provider
17 either by the entity or by the State agency;

18 “(G) for disclosure of information in ac-
19 cordance with subsection (g) and section 1124;

20 “(H) that any physician incentive plan op-
21 erated by the entity meets the requirements of
22 section 1876(i)(8);

23 “(I) for maintenance of sufficient patient
24 encounter data to identify the physician who de-
25 livers services to patients;

1 “(J) that the entity will comply with the
2 requirement of section 1902(w) with respect to
3 each enrollee;

4 “(K) that the entity will implement a
5 grievance system, inform enrollees in writing
6 about how to use such grievance system, ensure
7 that grievances are addressed in a timely man-
8 ner, and report grievances to the State at inter-
9 vals to be determined by the State;

10 “(L) that contracts between the entity and
11 each subcontractor of such entity will require
12 each subcontractor—

13 “(i) to cooperate with the entity in the
14 implementation of its internal quality as-
15 surance program under paragraph (4) and
16 adhere to the standards set forth in the
17 quality assurance program, including
18 standards with respect to access to care,
19 facilities in which patients receive care,
20 and availability, maintenance, and review
21 of medical records;

22 “(ii) to cooperate with the Secretary,
23 the State agency and any contractor to the
24 State in monitoring and evaluating the
25 quality and appropriateness of care pro-

1 vided to enrollees as required by Federal or
2 State laws and regulations; and

3 “(iii) where applicable, to adhere to
4 regulations and program guidance with re-
5 spect to reporting requirements under sec-
6 tion 1905(r);

7 “(M) that, where the State deems it nec-
8 essary to ensure the timely provision to enroll-
9 ees of the services listed in subsection
10 (f)(2)(C)(ii), the State may arrange for the pro-
11 vision of such services by health care providers
12 other than the entity and may adjust its pay-
13 ments to the entity accordingly;

14 “(N) that the entity and the State will
15 comply with guidelines and regulations issued
16 by the Secretary with respect to procedures for
17 marketing and information that must be pro-
18 vided to individuals eligible for medical assist-
19 ance under the State plan;

20 “(O) that the entity shall report to the
21 State, at such time and in such manner as the
22 State shall require, on the rates paid for hos-
23 pital services (by type of hospital and type of
24 service) furnished to individuals enrolled with
25 the entity;

1 “(P) detailed information regarding the
2 relative responsibilities of the entity and the
3 State, for providing (or arranging for the provi-
4 sion of), and making payment for, the following
5 items and services:

6 “(i) immunizations;

7 “(ii) the purchase of vaccines;

8 “(iii) lead screening and treatment
9 services;

10 “(iv) screening and treatment for tu-
11 berculosis;

12 “(v) screening and treatment for, and
13 preventive services related to, sexually
14 transmitted diseases, including HIV infec-
15 tion;

16 “(vi) screening, diagnostic, and treat-
17 ment services required under section
18 1905(r);

19 “(vii) family planning services;

20 “(viii) services prescribed under—

21 “(I) an Individual Education
22 Plan or Individualized Family Service
23 Plan under part B or part H of the
24 Individuals with Disabilities Edu-
25 cation Act; and

1 “(II) any other individual plan of
2 care or treatment developed under
3 this title or title V;

4 “(ix) transportation needed to obtain
5 services to which the enrollee is entitled
6 under the State plan or pursuant to an in-
7 dividual plan of care or treatment de-
8 scribed in subclauses (I) and (II) of clause
9 (viii); and

10 “(x) such other services as the Sec-
11 retary may specify;

12 “(Q) detailed information regarding the
13 procedures for coordinating the relative respon-
14 sibilities of the entity and the State to ensure
15 prompt delivery of, compliance with any appli-
16 cable reporting requirements related to, and ap-
17 propriate recordkeeping with respect to, the
18 items and services described in subparagraph
19 (P); and

20 “(R) such other provisions as the Sec-
21 retary may require.

22 “(4) INTERNAL QUALITY ASSURANCE.—A risk
23 contracting entity meets the requirements of this
24 section only if such entity has in effect a written in-
25 ternal quality assurance program which includes a

1 systematic process to achieve specified and measur-
2 able goals and objectives for access to, and quality
3 of, care, which—

4 “(A) identifies the organizational units re-
5 sponsible for performing specific quality assur-
6 ance functions, and ensures that such units are
7 accountable to the governing body of the entity
8 and that such units have adequate supervision,
9 staff, and other necessary resources to perform
10 these functions effectively,

11 “(B) if any quality assurance functions are
12 delegated to other entities, ensures that the risk
13 contracting entity remains accountable for all
14 quality assurance functions and has mecha-
15 nisms to ensure that all quality assurance ac-
16 tivities are carried out,

17 “(C) includes methods to ensure that phy-
18 sicians and other health care professionals
19 under contract with the entity are licensed or
20 certified as required by State law, or are other-
21 wise qualified to perform the services such phy-
22 sicians and other professionals provide, and
23 that these qualifications are ensured through
24 appropriate credentialing and recredentialing
25 procedures,

1 “(D) provides for continuous monitoring of
2 the delivery of health care, through—

3 “(i) identification of clinical areas to
4 be monitored, including immunizations,
5 prenatal care, services required under sec-
6 tion 1905(r), and other appropriate clinical
7 areas, to reflect care provided to enrollees
8 eligible for medical assistance under the
9 State plan,

10 “(ii) use of quality indicators and
11 standards for assessing the quality and ap-
12 propriateness of care delivered, and the
13 availability and accessibility of all services
14 for which the entity is responsible under
15 such entity’s contract with the State,

16 “(iii) use of epidemiological data or
17 chart review, as appropriate, and patterns
18 of care overall,

19 “(iv) patient surveys, spot checks, or
20 other appropriate methods to determine
21 whether—

22 “(I) enrollees are able to obtain
23 timely appointments with primary
24 care providers and specialists, and

1 “(II) enrollees are otherwise
2 guaranteed access and care as pro-
3 vided under paragraph (2),

4 “(v) provision of written information
5 to health care providers and other person-
6 nel on the outcomes, quality, availability,
7 accessibility, and appropriateness of care,
8 and

9 “(vi) implementation of corrective ac-
10 tions,

11 “(E) includes standards for timely enrollee
12 access to information and care which at a mini-
13 mum shall incorporate standards used by the
14 State or professional or accreditation bodies for
15 facilities furnishing perinatal and neonatology
16 care and other forms of specialized medical and
17 surgical care,

18 “(F) includes standards for the facilities in
19 which patients receive care,

20 “(G) includes standards for managing and
21 treating medical conditions prevalent among
22 such entity’s enrollees eligible for medical as-
23 sistance under the State plan,

24 “(H) includes mechanisms to ensure that
25 enrollees eligible for medical assistance under

1 the State plan receive services for which the en-
2 tity is responsible under the contract which are
3 consistent with standards established by the ap-
4 plicable professional societies or government
5 agencies,

6 “(I) includes standards for the availability,
7 maintenance, and review of medical records
8 consistent with generally accepted medical prac-
9 tice,

10 “(J) provides for dissemination of quality
11 assurance procedures to health care providers
12 under contract with the entity, and

13 “(K) meets any other requirements pre-
14 scribed by the Secretary or the State.

15 “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE
16 CASE MANAGEMENT PROGRAMS.—A primary care case
17 management program implemented by a State under this
18 section shall—

19 “(1) provide that each primary care case man-
20 agement entity participating in such program has a
21 written contract with the State agency,

22 “(2) include methods for selection and monitor-
23 ing of participating primary care case management
24 entities to ensure—

1 “(A) that the geographic locations, hours
2 of operation, patient to staff ratio, and other
3 relevant characteristics of such entities are suf-
4 ficient to afford individuals eligible for medical
5 assistance under the State plan access to such
6 entities that is at least equivalent to the access
7 to health care providers that would be available
8 to such individuals if such individuals were not
9 enrolled with such entity,

10 “(B) that such entities and their profes-
11 sional personnel are licensed as required by
12 State law and qualified to provide case manage-
13 ment services, through methods such as ongo-
14 ing monitoring of compliance with applicable re-
15 quirements and providing information and tech-
16 nical assistance, and

17 “(C) that such entities—

18 “(i) provide timely and appropriate
19 primary care to such enrollees consistent
20 with standards established by applicable
21 professional societies or governmental
22 agencies, or such other standards pre-
23 scribed by the Secretary or the State, and

24 “(ii) where other items and services
25 are determined to be medically necessary,

1 give timely approval of such items and
2 services and referral to appropriate health
3 care providers,

4 “(3) provide that no preapproval shall be re-
5 quired for emergency health care items or services,
6 and

7 “(4) permit individuals eligible for medical as-
8 sistance under the State plan who have enrolled with
9 a primary care case management entity to terminate
10 such enrollment without cause not later than the be-
11 ginning of the first calendar month following a full
12 calendar month after the request is made for such
13 termination.

14 “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-
15 MENTS.—A State plan may permit or require an individ-
16 ual eligible for medical assistance under such plan to en-
17 roll with a risk contracting entity or a primary care case
18 management entity without regard to the requirements set
19 forth in the following paragraphs of section 1902(a):

20 “(1) Paragraph (1) (concerning statewideness).

21 “(2) Paragraph (10)(B) (concerning com-
22 parability of benefits), to the extent benefits not in-
23 cluded in the State plan are provided.

24 “(3) Paragraph (23) (concerning freedom of
25 choice of provider), except with respect to services

1 described in section 1905(a)(4)(C) and except as re-
2 quired under subsection (e).

3 “(e) STATE OPTIONS WITH RESPECT TO ENROLL-
4 MENT AND DISENROLLMENT.—

5 “(1) MANDATORY ENROLLMENT.—A State plan
6 may require an individual eligible for medical assist-
7 ance under such plan to enroll with a risk contract-
8 ing entity or a primary care case management entity
9 only if the individual is permitted a choice within a
10 reasonable service area (as defined by the State)—

11 “(A) between or among 2 or more risk
12 contracting entities,

13 “(B) among a risk contracting entity and
14 a primary care case management program, or

15 “(C) among primary care case manage-
16 ment entities.

17 “(2) REENROLLMENT OF INDIVIDUALS WHO
18 REGAIN ELIGIBILITY.—In the case of an individual
19 who—

20 “(A) in a month is eligible for medical as-
21 sistance under the State plan and enrolled with
22 a risk contracting entity with a contract under
23 this section,

24 “(B) in the next month (or next 2 months)
25 is not eligible for such medical assistance, but

1 “(C) in the succeeding month is again eli-
2 gible for such benefits,
3 the State agency (subject to subsection (b)(3)(E))
4 may enroll the individual for that succeeding month
5 with such entity, if the entity continues to have a
6 contract with the State agency under this sub-
7 section.

8 “(3) DISENROLLMENT.—

9 “(A) RESTRICTIONS ON DISENROLLMENT
10 WITHOUT CAUSE.—Except as provided in sub-
11 paragraph (C), a State plan may restrict the
12 period in which individuals enrolled with risk
13 contracting entities described in paragraph (4)
14 may terminate such enrollment without cause to
15 the first month of each period of enrollment (as
16 defined in subparagraph (B)), but only if the
17 State provides notification, at least once during
18 each such enrollment period, to individuals en-
19 rolled with such entity of the right to terminate
20 such enrollment and the restriction on the exer-
21 cise of this right. Such restriction shall not
22 apply to requests for termination of enrollment
23 for cause.

1 “(B) PERIOD OF ENROLLMENT.—For pur-
2 poses of this paragraph, the term ‘period of en-
3 rollment’ means—

4 “(i) a period not to exceed 6 months
5 in duration, or

6 “(ii) a period not to exceed 1 year in
7 duration, in the case of a State that, on
8 the effective date of this paragraph, had in
9 effect a waiver under section 1115 of re-
10 quirements under this title under which
11 the State could establish a 1-year mini-
12 mum period of enrollment with risk con-
13 tracting entities.

14 “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT
15 RESTRICTIONS.—A risk contracting entity described
16 in this paragraph is—

17 “(A) a qualified health maintenance orga-
18 nization as defined in section 1310(d) of the
19 Public Health Service Act,

20 “(B) an eligible organization with a con-
21 tract under section 1876,

22 “(C) an entity that is receiving (and has
23 received during the previous 2 years) a grant of
24 at least \$100,000 under section 329(d)(1)(A)
25 or 330(d)(1) of the Public Health Service Act,

1 “(D) an entity that—

2 “(i) received a grant of at least
3 \$100,000 under section 329(d)(1)(A) or
4 section 330(d)(1) of the Public Health
5 Service Act in the fiscal year ending June
6 30, 1976, and has been a grantee under ei-
7 ther such section for all periods after that
8 date, and

9 “(ii) provides to its enrollees, on a
10 prepaid capitation or other risk basis, all
11 of the services described in paragraphs (1),
12 (2), (3), (4)(C), and (5) of section 1905(a)
13 (and the services described in section
14 1905(a)(7), to the extent required by sec-
15 tion 1902(a)(10)(D)),

16 “(E) an entity that is receiving (and has
17 received during the previous 2 years) at least
18 \$100,000 (by grant, subgrant, or subcontract)
19 under the Appalachian Regional Development
20 Act of 1965,

21 “(F) a nonprofit primary health care en-
22 tity located in a rural area (as defined by the
23 Appalachian Regional Commission)—

24 “(i) which received in the fiscal year
25 ending June 30, 1976, at least \$100,000

1 (by grant, subgrant, or subcontract) under
2 the Appalachian Regional Development Act
3 of 1965, and

4 “(ii) which, for all periods after such
5 date, either has been the recipient of a
6 grant, subgrant, or subcontract under such
7 Act or has provided services on a prepaid
8 capitation or other risk basis under a con-
9 tract with the State agency initially en-
10 tered into during a year in which the entity
11 was the recipient of such a grant,
12 subgrant, or subcontract,

13 “(G) an entity that had contracted with
14 the State agency prior to 1970 for the provi-
15 sion, on a prepaid risk basis, of services (which
16 did not include inpatient hospital services) to
17 individuals eligible for medical assistance under
18 the State plan,

19 “(H) a program pursuant to an undertak-
20 ing described in subsection (l)(3) in which at
21 least 25 percent of the membership enrolled on
22 a prepaid basis are individuals who—

23 “(i) are not insured for benefits under
24 part B of title XVIII or eligible for medical
25 assistance under the State plan, and

1 “(ii) (in the case of such individuals
2 whose prepayments are made in whole or
3 in part by any government entity) had the
4 opportunity at the time of enrollment in
5 the program to elect other coverage of
6 health care costs that would have been
7 paid in whole or in part by any govern-
8 mental entity,

9 “(I) an entity that, on the date of enact-
10 ment of this provision, had a contract with the
11 State agency under a waiver under section 1115
12 or 1915(b) and was not subject to a require-
13 ment under this title to permit disenrollment
14 without cause, or

15 “(J) an entity that has a contract with the
16 State agency under a waiver under section
17 1915(b)(5).

18 “(f) STATE MONITORING AND EXTERNAL REVIEW.—

19 “(1) STATE GRIEVANCE PROCEDURE.—A State
20 contracting with a risk contracting entity or a pri-
21 mary care case management entity under this sec-
22 tion shall provide for a grievance procedure for en-
23 rollees of such entity with at least the following ele-
24 ments:

1 “(A) a toll-free telephone number for en-
2 rollee questions and grievances,

3 “(B) periodic notification of enrollees of
4 their rights with respect to such entity or pro-
5 gram,

6 “(C) periodic sample reviews of grievances
7 registered with such entity or program or with
8 the State, and

9 “(D) periodic survey and analysis of en-
10 rollee satisfaction with such entity or program,
11 including interviews with individuals who
12 disenroll from the entity or program.

13 “(2) STATE MONITORING OF QUALITY AND AC-
14 CESS.—

15 “(A) RISK CONTRACTING ENTITIES.—A
16 State contracting with a risk contracting entity
17 under this section shall provide for ongoing
18 monitoring of such entity’s compliance with the
19 requirements of subsection (b), including com-
20 pliance with the requirements of such entity’s
21 contract under subsection (b)(3), and shall un-
22 dertake appropriate followup activities to ensure
23 that any problems identified are rectified and
24 that compliance with the requirements of sub-

1 section (b) and the requirements of the contract
2 under subsection (b)(3) is maintained.

3 “(B) PRIMARY CARE CASE MANAGEMENT
4 ENTITIES.—A State electing to implement a
5 primary care case management program shall
6 provide for ongoing monitoring of the pro-
7 gram’s compliance with the requirements of
8 subsection (c) and shall undertake appropriate
9 followup activities to ensure that any problems
10 identified are rectified and that compliance with
11 subsection (c) is maintained.

12 “(C) SERVICES.—

13 “(i) IN GENERAL.—The State shall
14 establish procedures (in addition to those
15 required under subparagraphs (A) and
16 (B)) to ensure that the services listed in
17 clause (ii) are available in a timely manner
18 to an individual enrolled with a risk con-
19 tracting entity or a primary care case man-
20 agement entity. Where necessary to ensure
21 the timely provision of such services, the
22 State shall arrange for the provision of
23 such services by health care providers
24 other than the risk contracting entity or

1 the primary care case management entity
2 in which an individual is enrolled.

3 “(ii) SERVICES LISTED.—The services
4 listed in this clause are:

5 “(I) prenatal care;

6 “(II) immunizations;

7 “(III) lead screening and treat-
8 ment;

9 “(IV) prevention, diagnosis and
10 treatment of tuberculosis, sexually
11 transmitted diseases (including HIV
12 infection), and other communicable
13 diseases; and

14 “(V) such other services as the
15 Secretary may specify.

16 “(iii) REPORT.—The procedures re-
17 ferred to in clause (i) shall be described in
18 an annual report to the Secretary provided
19 by the State.

20 “(3) EXTERNAL INDEPENDENT REVIEW.—

21 “(A) IN GENERAL.—Except as provided in
22 paragraph (4), a State contracting with a risk
23 contracting entity under this section shall pro-
24 vide for an annual external independent review
25 of the quality and timeliness of, and access to,

1 the items and services specified in such entity's
2 contract with the State agency. Such review
3 shall be conducted by a utilization control and
4 peer review organization with a contract under
5 section 1153 or another organization unaffili-
6 ated with the State government or with any
7 risk contracting entity and approved by the
8 Secretary.

9 “(B) CONTENTS OF REVIEW.—An external
10 independent review conducted under this para-
11 graph shall include the following:

12 “(i) a review of the entity's medical
13 care, through sampling of medical records
14 or other appropriate methods, for indica-
15 tions of quality of care and inappropriate
16 utilization (including overutilization) and
17 treatment,

18 “(ii) a review of enrollee inpatient and
19 ambulatory data, through sampling of
20 medical records or other appropriate meth-
21 ods, to determine trends in quality and ap-
22 propriateness of care,

23 “(iii) notification of the entity and the
24 State when the review under this para-
25 graph indicates inappropriate care, treat-

1 ment, or utilization of services (including
2 overutilization), and

3 “(iv) other activities as prescribed by
4 the Secretary or the State.

5 “(C) AVAILABILITY.—The results of each
6 external independent review conducted under
7 this paragraph shall be available to the public
8 consistent with the requirements for disclosure
9 of information contained in section 1160.

10 “(4) DEEMED COMPLIANCE WITH EXTERNAL
11 INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-
12 MENTS.—

13 “(A) IN GENERAL.—The Secretary may
14 deem the State to have fulfilled the requirement
15 for independent external review of quality of
16 care with respect to an entity which has been
17 accredited by an organization described in sub-
18 paragraph (B) and approved by the Secretary.

19 “(B) ACCREDITING ORGANIZATION.—An
20 accrediting organization described in this sub-
21 paragraph must—

22 “(i) exist for the primary purpose of
23 accrediting coordinated care organizations;

24 “(ii) be governed by a group of indi-
25 viduals representing health care providers,

1 purchasers, regulators, and consumers (a
2 minority of which shall be representatives
3 of health care providers);

4 “(iii) have substantial experience in
5 accrediting coordinated care organizations,
6 including an organization’s internal quality
7 assurance program;

8 “(iv) be independent of health care
9 providers or associations of health care
10 providers;

11 “(v) be a nonprofit organization; and

12 “(vi) have an accreditation process
13 which meets requirements specified by the
14 Secretary.

15 “(5) FEDERAL MONITORING RESPONSIBIL-
16 ITIES.—The Secretary shall review the external inde-
17 pendent reviews conducted pursuant to paragraph
18 (3) and shall monitor the effectiveness of the State’s
19 monitoring and followup activities required under
20 subparagraph (A) of paragraph (2). If the Secretary
21 determines that a State’s monitoring and followup
22 activities are not adequate to ensure that the re-
23 quirements of paragraph (2) are met, the Secretary
24 shall undertake appropriate followup activities to en-

1 sure that the State improves its monitoring and fol-
2 lowup activities.

3 “(g) TRANSACTIONS WITH PARTIES IN INTEREST.—

4 “(1) IN GENERAL.—Each risk contracting en-
5 tity which is not a qualified health maintenance or-
6 ganization (as defined in section 1310(d) of the
7 Public Health Service Act) must report to the State
8 and, upon request, to the Secretary, the Inspector
9 General of the Department of Health and Human
10 Services, and the Comptroller General of the United
11 States a description of transactions between the en-
12 tity and a party in interest (as defined in section
13 1318(b) of such Act), including the following trans-
14 actions:

15 “(A) Any sale or exchange, or leasing of
16 any property between the entity and such a
17 party.

18 “(B) Any furnishing for consideration of
19 goods, services (including management serv-
20 ices), or facilities between the entity and such
21 a party, but not including salaries paid to em-
22 ployees for services provided in the normal
23 course of their employment.

1 “(C) Any lending of money or other exten-
2 sion of credit between the entity and such a
3 party.

4 The State or the Secretary may require that infor-
5 mation reported with respect to a risk contracting
6 entity which controls, or is controlled by, or is under
7 common control with, another entity be in the form
8 of a consolidated financial statement for the risk
9 contracting entity and such entity.

10 “(2) AVAILABILITY OF INFORMATION.—Each
11 risk contracting entity shall make the information
12 reported pursuant to paragraph (1) available to its
13 enrollees upon reasonable request.

14 “(h) REMEDIES FOR FAILURE TO COMPLY.—

15 “(1) IN GENERAL.—If the Secretary determines
16 that a risk contracting entity or a primary care case
17 management entity—

18 “(A) fails substantially to provide services
19 required under section 1905(r), when such an
20 entity is required to do so, or provide medically
21 necessary items and services that are required
22 to be provided to an individual enrolled with
23 such an entity, if the failure has adversely af-
24 fected (or has substantial likelihood of adversely
25 affecting) the individual;

1 “(B) imposes premiums on individuals en-
2 rolled with such an entity in excess of the pre-
3 miums permitted under this title;

4 “(C) acts to discriminate among individ-
5 uals in violation of the provision of subsection
6 (b)(3)(D), including expulsion or refusal to
7 reenroll an individual or engaging in any prac-
8 tice that would reasonably be expected to have
9 the effect of denying or discouraging enrollment
10 (except as permitted by this section) by eligible
11 individuals with the entity whose medical condi-
12 tion or history indicates a need for substantial
13 future medical services;

14 “(D) misrepresents or falsifies information
15 that is furnished—

16 “(i) to the Secretary or the State
17 under this section; or

18 “(ii) to an individual or to any other
19 entity under this section; or

20 “(E) fails to comply with the requirements
21 of section 1876(i)(8),

22 the Secretary may provide, in addition to any other
23 remedies available under law, for any of the rem-
24 edies described in paragraph (2).

1 “(2) ADDITIONAL REMEDIES.—The remedies
2 described in this paragraph are—

3 “(A) civil money penalties of not more
4 than \$25,000 for each determination under
5 paragraph (1), or, with respect to a determina-
6 tion under subparagraph (C) or (D)(i) of such
7 paragraph, of not more than \$100,000 for each
8 such determination, plus, with respect to a de-
9 termination under paragraph (1)(B), double the
10 excess amount charged in violation of such
11 paragraph (and the excess amount charged
12 shall be deducted from the penalty and returned
13 to the individual concerned), and plus, with re-
14 spect to a determination under paragraph
15 (1)(C), \$15,000 for each individual not enrolled
16 as a result of a practice described in such para-
17 graph, or

18 “(B) denial of payment to the State for
19 medical assistance furnished by a risk contract-
20 ing entity or a primary care case management
21 entity under this section for individuals enrolled
22 after the date the Secretary notifies the entity
23 of a determination under paragraph (1) and
24 until the Secretary is satisfied that the basis for

1 such determination has been corrected and is
2 not likely to recur.

3 The provisions of section 1128A (other than sub-
4 sections (a) and (b)) shall apply to a civil money
5 penalty under subparagraph (A) in the same manner
6 as such provisions apply to a penalty or proceeding
7 under section 1128A(a).

8 “(i) TERMINATION OF CONTRACT BY STATE.—Any
9 State which has a contract with a risk contracting entity
10 or a primary care case management entity may terminate
11 such contract if such entity fails to comply with the terms
12 of such contract or any applicable provision of this section.

13 “(j) FAIR HEARING.—Nothing in this section shall
14 affect the rights of an individual eligible to receive medical
15 assistance under the State plan to obtain a fair hearing
16 under section 1902(a)(3) or under applicable State law.

17 “(k) REFERRAL PAYMENTS.—For 1 year following
18 the date on which individuals eligible for medical assist-
19 ance under the State plan in a service area are required
20 to enroll with a risk contracting entity or a primary care
21 case management entity, Federally qualified health cen-
22 ters and rural health centers located in such service area
23 or providing care to such enrollees, shall receive a fee for
24 educating such enrollees about the availability of services

1 from the risk contracting entity or primary care case man-
2 agement entity with which such enrollees are enrolled.

3 “(l) SPECIAL RULES.—

4 “(1) NONAPPLICABILITY OF CERTAIN PROVI-
5 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—

6 In the case of any risk contracting entity which—

7 “(A)(i) is an individual physician or a phy-
8 sician group practice of less than 50 physicians,
9 and

10 “(ii) is not described in paragraphs (A)
11 and (B) of subsection (b)(1), and

12 “(B) is at risk only for the health care
13 items and services directly provided by such en-
14 tity,

15 paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)
16 of subsection (b), and paragraph (3) of subsection
17 (f), shall not apply to such entity.

18 “(2) EXCEPTION FROM DEFINITION OF RISK
19 CONTRACTING ENTITY.—For purposes of this sec-
20 tion, the term ‘risk contracting entity’ shall not in-
21 clude a health insuring organization which was used
22 by a State before April 1, 1986, to administer a por-
23 tion of the State plan of such State on a statewide
24 basis.

1 “(3) NEW JERSEY.—The rules under section
2 1903(m)(6) as in effect on the day before the effec-
3 tive date of this section shall apply in the case of an
4 undertaking by the State of New Jersey (as de-
5 scribed in such section 1903(m)(6)).

6 “(m) CONTINUATION OF CERTAIN COORDINATED
7 CARE PROGRAMS.—The Secretary may provide for the
8 continuation of any coordinated care program operating
9 under section 1115 or 1915 without requiring compliance
10 with any provision of this section which conflicts with the
11 continuation of such program and without requiring any
12 additional waivers under such sections 1115 and 1915 if
13 the program has been successful in assuring quality and
14 containing costs (as determined by the Secretary) and is
15 likely to continue to be successful in the future.

16 “(n) GUIDELINES AND MODEL CONTRACT.—

17 “(1) GUIDELINES ON SOLVENCY.—At the earli-
18 est practicable time after the date of enactment of
19 this section, the Secretary shall issue guidelines con-
20 cerning solvency standards for risk contracting enti-
21 ties and subcontractors of such risk contracting enti-
22 ties. Such guidelines shall take into account charac-
23 teristics that may differ among risk contracting enti-
24 ties including whether such an entity is at risk for
25 inpatient hospital services.

1 “(2) GUIDELINES ON MARKETING.—At the ear-
2 liest practicable time after the date of enactment of
3 this section, the Secretary shall issue guidelines con-
4 cerning—

5 “(A) marketing undertaken by any risk
6 contracting entity or any primary care case
7 management program to individuals eligible for
8 medical assistance under the State plan, and

9 “(B) information that must be provided by
10 States or any such entity to individuals eligible
11 for medical assistance under the State plan
12 with respect to—

13 “(i) the options and rights of such in-
14 dividuals to enroll with, and disenroll from,
15 any such entity, as provided in this section,
16 and

17 “(ii) the availability of services from
18 any such entity (including a list of services
19 for which such entity is responsible or
20 must approve and information on how to
21 obtain services for which such entity is not
22 responsible).

23 In developing the guidelines under this paragraph,
24 the Secretary shall address the special circumstances
25 of children with special health care needs (as defined

1 in subsection (e)(1)(B)(ii)) and other individuals
2 with special health care needs.

3 “(3) MODEL CONTRACT.—The Secretary shall
4 develop a model contract to reflect the requirements
5 of subsection (b)(3) and such other requirements as
6 the Secretary determines appropriate.”

7 (b) WAIVERS FROM REQUIREMENTS ON COORDI-
8 NATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C.
9 1396n) is amended—

10 (1) in the matter preceding paragraph (1), by
11 striking “as may be necessary” and inserting “, and
12 section 1931 as may be necessary”;

13 (2) in paragraph (1), by striking “a primary
14 care case management system or”;

15 (3) by striking “and” at the end of paragraph
16 (3);

17 (4) by striking the period at the end of para-
18 graph (4) and inserting “, and”; and

19 (5) by inserting after paragraph (4) the follow-
20 ing new paragraph:

21 “(5) to permit a risk contracting entity (as de-
22 fined in section 1931(a)(3)) to restrict the period in
23 which individuals enrolled with such entity may ter-
24minate such enrollment without cause in accordance
25 with section 1931(e)(3)(A).”.

1 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-
2 BILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is
3 amended—

4 (1) in subparagraph (A), by striking all that
5 precedes “(but for this paragraph)” and inserting
6 “In the case of an individual who is enrolled—

7 “(i) with a qualified health maintenance
8 organization (as defined in title XIII of the
9 Public Health Service Act) or with a risk con-
10 tracting entity (as defined in section
11 1931(a)(3)), or

12 “(ii) with any risk contracting entity (as
13 defined in section 1931(a)(3)) in a State that,
14 on the effective date of this provision, had in ef-
15 fect a waiver under section 1115 of require-
16 ments under this title under which the State
17 could extend eligibility for medical assistance
18 for enrollees of such entity, or

19 “(iii) with an eligible organization with a
20 contract under section 1876,
21 and who would”,

22 (2) in subparagraph (B), by striking “organiza-
23 tion or” each place it appears, and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 “(C) The State plan may provide, notwith-
 2 standing any other provision of this title, that
 3 an individual shall be deemed to continue to be
 4 eligible for benefits under this title until the end
 5 of the month following the month in which such
 6 individual would (but for this paragraph) lose
 7 such eligibility because of excess income and re-
 8 sources, if the individual is enrolled with a risk
 9 contracting entity or primary care case manage-
 10 ment entity (as those terms are defined in sec-
 11 tion 1931(a)).”.

12 (d) ENHANCED MATCH RELATED TO QUALITY RE-
 13 VIEW.—Section 1903(a)(3)(C) (42 U.S.C.
 14 1396b(a)(3)(C)) is amended—

15 (1) by striking “organization or by” and insert-
 16 ing “organization, by”; and

17 (2) by striking “section 1152, as determined by
 18 the Secretary,” and inserting “section 1152, as de-
 19 termined by the Secretary, or by another organiza-
 20 tion approved by the Secretary which is unaffiliated
 21 with the State government or with any risk contract-
 22 ing entity (as defined in section 1931(a)(3)),”.

23 (e) CONFORMING AMENDMENTS.—

24 (1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a-
 25 7(b)(6)(C)(i)) is amended by striking “health main-

1 tenance organization” and inserting “risk contract-
2 ing entity”.

3 (2) Section 1902(a)(23) (42 U.S.C.
4 1396a(a)(23)) is amended by striking “primary
5 care-case management system (described in section
6 1915(b)(1)), a health maintenance organization,”
7 and inserting “primary care case management pro-
8 gram (as defined in section 1931(a)(1)), a risk con-
9 tracting entity (as defined in section 1931(a)(3)),”.

10 (3) Section 1902(a)(30)(C) (42 U.S.C.
11 1396a(a)(30)(C)) is amended by striking “use a uti-
12 lization” and all that follows through “with the re-
13 sults” and inserting “provide for independent review
14 and quality assurance of entities with contracts
15 under section 1931, in accordance with subsection
16 (f) of such section 1931, with the results”.

17 (4) Section 1902(a)(57) (42 U.S.C.
18 1396a(a)(57)) is amended by striking “or health
19 maintenance organization (as defined in section
20 1903(m)(1)(A))” and inserting “risk contracting en-
21 tity, or primary care case management entity (as de-
22 fined in section 1931(a))”.

23 (5) Section 1902(a) (42 U.S.C. 1396a), as
24 amended by sections 121, 201(a), 851, 854, and
25 855, is amended—

1 (A) by striking “and” at the end of para-
2 graph (66);

3 (B) by striking the period at the end of
4 paragraph (67) and inserting “; and”; and

5 (C) by adding at the end the following new
6 paragraphs:

7 “(68) at State option, provide for a primary
8 care case management program in accordance with
9 section 1931; and

10 “(69) at State option, provide for a program
11 under which the State contracts with risk contract-
12 ing entities in accordance with section 1931.”.

13 (6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2))
14 is amended by striking “health maintenance organi-
15 zation (as defined in section 1903(m))” and insert-
16 ing “risk contracting entity (as defined in section
17 1931(a)(3))”.

18 (7) Section 1902(w) (42 U.S.C. 1396a(w)) is
19 amended—

20 (A) in paragraph (1), by striking “section
21 1903(m)(1)(A)” and inserting “section
22 1931(a)(3)”, and

23 (B) in paragraph (2)(E)—

1 (i) by striking “health maintenance
2 organization” and inserting “risk contract-
3 ing entity”, and

4 (ii) by striking “organization” and in-
5 serting “entity”.

6 (8) Section 1903(k) (42 U.S.C. 1396b(k)) is
7 amended by striking “health maintenance organiza-
8 tion which meets the requirements of subsection (m)
9 of this section” and inserting “risk contracting en-
10 tity which meets the requirements of section 1931”.

11 (9) Section 1903(w)(7)(A)(viii) (42 U.S.C.
12 1396b(w)(7)(A)(viii)) is amended by striking “health
13 maintenance organizations (and other organizations
14 with contracts under section 1903(m))” and insert-
15 ing “risk contracting entities with contracts under
16 section 1931”.

17 (10) Section 1905(a) (42 U.S.C. 1396d(a)) is
18 amended, in the matter preceding clause (i), by in-
19 serting “(which may be on a prepaid capitation or
20 other risk basis)” after “payment”.

21 (11) Section 1916(b)(2)(D) (42 U.S.C.
22 1396o(b)(2)(D)) is amended by striking “health
23 maintenance organization (as defined in section
24 1903(m))” and inserting “risk contracting entity (as
25 defined in section 1931(a)(3))”.

1 (12) Section 1925(b)(4)(D)(iv) (42 U.S.C.
2 1396r-6(b)(4)(D)(iv)) is amended—

3 (A) in the heading, by striking “**HMO**”
4 and inserting “**RISK CONTRACTING ENTITY**”,

5 (B) by striking “health maintenance orga-
6 nization (as defined in section 1903(m)(1)(A))”
7 and inserting “risk contracting entity (as de-
8 fined in section 1931(a)(3)”, and

9 (C) by striking “health maintenance orga-
10 nization in accordance with section 1903(m))”
11 and inserting “risk contracting entity in accord-
12 ance with section 1931”.

13 (13) Paragraphs (1) and (2) of section 1926(a)
14 (42 U.S.C. 1396r-7(a)) are each amended by strik-
15 ing “health maintenance organizations under section
16 1903(m))” and inserting “risk contracting entities
17 under section 1931”.

18 (13) Section 1927(j)(1) is amended by striking
19 “* * * Health Maintenance Organizations, includ-
20 ing those organizations that contract under section
21 1903(m))” and inserting “risk contracting entities
22 (as defined in section 1931(a)(3))”.

23 (f) EFFECTIVE DATE.—The amendments made by
24 this section shall become effective with respect to calendar
25 quarters beginning on or after January 1, 1995.

1 **PART III—LONG-TERM CARE PROVISIONS**

2 **SEC. 871. STATE OPTION TO PROVIDE HOME OR COMMU-**
3 **NITY BASED CARE SERVICES.**

4 (a) PROVISION AS OPTIONAL SERVICE.—Section
5 1905(a) (42 U.S.C. 1396d(a)) is amended—

6 (1) by striking “and” at the end of paragraph
7 (24);

8 (2) by redesignating paragraph (25) as para-
9 graph (26); and

10 (3) by inserting after paragraph (24) the fol-
11 lowing new paragraph:

12 “(25) home or community based services (as
13 defined in section 1905(t)).”.

14 (b) DEFINITION.—Section 1905 (42 U.S.C. 1396d)
15 is amended by adding at the end the following new sub-
16 section:

17 “(t) The term ‘home or community based services’
18 means services (other than room and board) approved by
19 the Secretary which are provided pursuant to a written
20 plan of care to individuals who require the level of care
21 provided in a hospital, nursing facility, or intermediate
22 care facility for the mentally retarded, the cost of which
23 could be reimbursed under the State plan. For purposes
24 of this subsection, the term ‘room and board’ shall not
25 include an amount established under a method determined
26 by the State to reflect the portion of costs of rent and

1 food attributable to an unrelated personal caregiver who
2 is residing in the same household with an individual who,
3 but for assistance of such caregiver, would require admis-
4 sion to a hospital, nursing facility, or intermediate care
5 facility for the mentally retarded.”.

6 (c) CONFORMING AMENDMENTS.—(1) Section
7 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is
8 amended by striking “through (24)” and inserting
9 “through (25)”.

10 (2) Section 1902(j) (42 U.S.C. 1396a(j)) is amended
11 by striking “through (25)” and inserting “through (26)”.

12 **SEC. 872. ELIMINATION OF RULE REGARDING AVAILABIL-**
13 **ITY OF BEDS IN CERTAIN INSTITUTIONS.**

14 (a) IN GENERAL.—The first sentence of section
15 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by insert-
16 ing the following before the end period: “(at the option
17 of the State, such determination may be made without re-
18 gard to the availability of beds in such a hospital, nursing
19 facility, or intermediate care facility for the mentally re-
20 tarder located in the State)”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall be effective with respect to waivers
23 granted or renewed on or after January 1, 1995.

1 **SEC. 873. CERTAIN DEMONSTRATION PROJECTS PER-**
2 **MITTED UNDER THE MEDICAID PROGRAM.**

3 (a) IN GENERAL.—Section 1917(b) of the Social Se-
4 curity Act (42 U.S.C. 1396p(b)) is amended—

5 (1) in paragraph (1), by striking subparagraph
6 (C);

7 (2) in paragraph (3), by striking “(other than
8 paragraph (1)(C))”; and

9 (3) in paragraph (4)(B), by striking “(and shall
10 include, in the case of an individual to whom para-
11 graph (1)(C)(i) applies)”.

12 (b) EFFECTIVE DATE.—Section 1917(b) of the So-
13 cial Security Act (42 U.S.C. 1396p(b)) shall be applied
14 and administered as if the provisions stricken by para-
15 graph (1) had not been enacted.

16 **SEC. 874. ELIMINATION OF REQUIREMENT OF PRIOR INSTI-**
17 **TUTIONALIZATION WITH RESPECT TO HA-**
18 **BILITATION SERVICES FURNISHED UNDER A**
19 **WAIVER FOR HOME OR COMMUNITY-BASED**
20 **SERVICES.**

21 (a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C.
22 1396n(c)(5)) is amended in the matter preceding subpara-
23 graph (A) by striking “, with respect to individuals who
24 receive such services after discharge from a nursing facil-
25 ity or intermediate care facility for the mentally retarded”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 1995.

4 **SEC. 875. RELIEF FROM THIRD PARTY LIABILITY REQUIRE-**
5 **MENTS WHEN COST-EFFECTIVE.**

6 (a) IN GENERAL.—Section 1902(a)(25)(B) (42
7 U.S.C. 1396a(a)(25)(B)) is amended to read as follows—
8 “(B) that in any case where such a legal liabil-
9 ity is found to exist after medical assistance has
10 been made available, the State or local agency will
11 seek reimbursement for such assistance to the extent
12 of such legal liability, unless—

13 “(i) the amount of reimbursement the
14 State can reasonably expect to recover for medi-
15 cal assistance furnished to an individual does
16 not exceed the costs of such recovery, or

17 “(ii) with respect to case management
18 services (as defined in section 1915(g)(2)), the
19 State demonstrates to the satisfaction of the
20 Secretary that it is not cost-effective in the ag-
21 gregate to seek such recovery with respect to
22 such services furnished to individuals covered
23 under the State plan, using methods specified
24 by the Secretary which may include a dem-

1 onstration that such services are not generally
2 covered by health insurers in the State;”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 this section shall become effective on January 1, 1995.

5 **SEC. 876. STATE EXPENDITURES FOR MEDICAL ASSIST-**
6 **ANCE WITH RESPECT TO HOME AND COMMU-**
7 **NITY-BASED SERVICES PROVIDED UNDER A**
8 **WAIVER.**

9 (a) IN GENERAL.—Section 1915(d)(5)(B) (42 U.S.C.
10 1396n(d)(5)(B)) is amended—

11 (1) in clause (i), by striking “times the number
12 of years” and inserting “compounded annually for
13 years”;

14 (2) in clause (ii), by striking “times the number
15 of years” and inserting “compounded annually for
16 years”; and

17 (3) in clause (iv), by striking “December 22,
18 1987” and inserting “the date of the enactment of
19 the Omnibus Budget Reconciliation Act of 1986”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall be effective as if included in the enact-
22 ment of the Omnibus Budget Reconciliation Act of 1987.

1 **SEC. 877. EXTENSION AND CONSOLIDATION OF FRAIL EL-**
2 **DERLY DEMONSTRATION PROJECT WAIVERS.**

3 (a) ELIMINATION OF LIMIT ON NUMBER OF WAIV-
4 ERS.—

5 (1) IN GENERAL.—Section 9412(b)(1) of the
6 Omnibus Budget Reconciliation Act of 1986 is
7 amended by striking “not more than 15”.

8 (2) TRANSITION.—The Secretary of Health and
9 Human Services shall grant waivers under section
10 9412(b) of the Omnibus Budget Reconciliation Act
11 of 1986 to not more than—

12 (A) 50 organizations before July 1, 1995,

13 or

14 (B) 75 organizations before July 1, 1996.

15 (b) INDEFINITE EXTENSION OF PARTICIPATION AND
16 STATUS AS PROVIDERS.—Section 9412(b)(2) of the Om-
17 nibus Budget Reconciliation Act of 1986 is amended—

18 (1) in subparagraph (A), by striking “subpara-
19 graph (B)” and inserting “this paragraph”,

20 (2) in subparagraph (A), by adding at the end
21 the following: “Except as otherwise provided by law
22 or regulation, such terms and conditions, with re-
23 spect to an organization, shall be substantially equiv-
24 alent to the terms and conditions provided under the
25 Protocol for the Program of All-inclusive Care for
26 the Elderly (PACE), as published by On Lok, Inc.

1 (and as recognized by the Health Care Financing
2 Administration) as of June 30, 1994, and made gen-
3 erally available.”;

4 (2) in subparagraph (C), by striking “may ex-
5 tend” and inserting “shall extend for an indefinite
6 period”; and

7 (3) by adding at the end the following:

8 “(D) Upon successful completion of the initial period
9 of the waiver under this subsection, an organization shall
10 be afforded regular provider status under titles XVIII and
11 XIX of the Social Security Act in accordance with appro-
12 priate regulations to be promulgated by the Secretary.
13 This subparagraph shall apply to organizations operating
14 under a waiver on or after July 1, 1997.

15 “(E) The provisions of this paragraph also shall
16 apply to the organization under the On Lok waiver de-
17 scribed in subparagraph (A).

18 “(F) Organizations under this paragraph shall ordi-
19 narily be reimbursed on a capitation basis. The organiza-
20 tions may provide additional services as may be deemed
21 appropriate by the organizations without regard to wheth-
22 er such services are specifically reimbursable through capi-
23 tation payments.”.

24 (c) TREATMENT OF APPLICATIONS.—Section
25 9412(b)(1) of such Act is amended by adding at the end

1 the following: “An appropriately completed application for
2 a waiver under this subsection is deemed approved unless
3 the Secretary specifically disapproves it in writing within
4 90 days of the date of its filing (or, if the Secretary re-
5 quests reasonable and substantial additional information
6 within such 90 day period, within 90 days of the date of
7 providing such additional information). The Secretary
8 shall have sole authority to approve or disapprove the ini-
9 tial and subsequent eligibility of an organization for a
10 waiver and shall make such determinations in a timely
11 manner.”.

12 (d) PROMOTION OF ADDITIONAL APPLICATIONS.—
13 Section 9412(b) of such Act is amended by adding at the
14 end the following:

15 “(5) The Secretary shall institute an organized
16 effort to promote the development of organizations
17 under this subsection.”.

18 (e) PROVISION OF ADDITIONAL SERVICES.—Section
19 9412(b) of such Act, as amended by subsection (d), is fur-
20 ther amended by adding at the end the following:

21 “(6) Nothing in this subsection shall prevent an
22 organization with a waiver under this subsection
23 from developing and providing appropriate services
24 to frail populations that may not be elderly, except
25 where the Secretary finds that such an extension im-

1 pair the ability of the organization to provide serv-
2 ices required under the waiver.”.

3 **SEC. 878. CERTAIN IMPROVEMENTS IN MEDICAID CASE**
4 **MANAGEMENT SERVICES AND HOME AND**
5 **COMMUNITY-BASED WAIVERS.**

6 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
7 1396a) is amended—

8 (1) in paragraph (23), by inserting “(including
9 case management services under subsections (c), (d),
10 and (g) of such section)” after “in section 1915”;
11 and

12 (2) in paragraph (32)—

13 (A) by striking the period at the end of
14 subparagraph (C) and inserting “; and”; and

15 (B) by adding at the end the following new
16 subparagraph:

17 “(D) in the case of services arranged
18 through the case management agency under
19 subsections (c), (d), or (g) of section 1915, pay-
20 ments made by the case management agency to
21 providers of services shall be permitted provided
22 that—

23 “(i) the case management entity is a
24 nonprofit entity;

1 “(ii) the case management entity
 2 maintains a clear system of records dem-
 3 onstrating conformity between payments
 4 made and services required under the indi-
 5 vidual’s plan of care; and

6 “(iii) the entity makes assurances sat-
 7 isfactory to the State that providers paid
 8 by the entity, for covered services to indi-
 9 viduals eligible under this title, are eligible
 10 for payments under the provisions of this
 11 title;”.

12 (b) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to payments for medical assistance
 14 for calendar quarters beginning on or after January 1,
 15 1995.

16 **PART IV—OTHER PROVISIONS**

17 **SEC. 881. AMENDMENTS TO PROVISIONS REQUIRING** 18 **STATES TO MAKE DSH PAYMENT ADJUST-** 19 **MENTS.**

20 (a) IN GENERAL.—

21 (1) ADJUSTMENT TO NATIONAL DSH PAYMENT
 22 LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r-
 23 4(f)(1)(B)) is amended by striking “12 percent” and
 24 inserting “9 percent”.

1 (2) ADJUSTMENTS TO STATE ALLOTMENT LIM-
 2 ITS.—Section 1923(f)(2)(B)(i) (42 U.S.C. 1396r-
 3 4(f)(2)(B)(i)) is amended by striking “12 percent”
 4 and inserting “9 percent”.

5 (3) ADJUSTMENT RELATING TO HIGH DSH
 6 STATES.—

7 (A) IN GENERAL.—Section
 8 1923(f)(2)(B)(i) (42 U.S.C. 1396r-
 9 4(f)(2)(B)(i)) is amended by striking “the State
 10 DSH allotment shall equal the State based al-
 11 lotment” and inserting “the State DSH allot-
 12 ment shall be an amount equal to the State
 13 based allotment less 25 percent of such allot-
 14 ment”.

15 (4) EFFECTIVE DATE.—The amendments made
 16 by this section shall be effective for calendar quar-
 17 ters beginning on or after January 1, 1997.

18 **SEC. 882. RECOMMENDATIONS BY THE SECRETARY ON A**
 19 **PHASED-IN ELIMINATION OF MEDICAID HOS-**
 20 **PITAL DISPROPORTIONATE SHARE ADJUST-**
 21 **MENT PAYMENTS.**

22 Not later than January 1, 2000, the Secretary shall
 23 submit recommendations to Congress on a phased-in
 24 elimination of the hospital disproportionate share adjust-

1 ment payments under section 1923 of the Social Security
2 Act.

3 **SEC. 883. REVISION OF FEDERAL MEDICAL ASSISTANCE**
4 **PERCENTAGE FOR CERTAIN STATES.**

5 (a) IN GENERAL.—Section 1905(b) (42 U.S.C.
6 1396d(b)) is amended—

7 (1) by redesignating clauses (1) and (2) as
8 clauses (2) and (3) and by inserting after “except
9 that” the following: “(1) for Alaska, the State per-
10 centage shall be that percentage which bears the
11 same ratio to 45 per centum as the square of the
12 adjusted per capita income of such State bears to
13 the square of the per capita income of the United
14 States;”; and

15 (2) by inserting after the first sentence the fol-
16 lowing: “The ‘adjusted per capita income’ for Alaska
17 shall be determined by dividing the State 3-year av-
18 erage per capita income by 1.25.”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall become effective on October 1, 1995.

21 **SEC. 884. CRITERIA FOR DETERMINING THE AMOUNT OF**
22 **DISALLOWANCES.**

23 (a) IN GENERAL.—

1 (1) CRITERIA FOR INITIAL DETERMINATIONS.—

2 Section 1903 (42 U.S.C. 1396b) is amended by add-
3 ing at the end the following new subsection:

4 “(x) If the Secretary determines that a disallowance
5 of Federal financial participation should be made under
6 this title with respect to any item or class of items, the
7 Secretary shall, in making a determination with respect
8 to the amount of such disallowance, take into account (to
9 the extent the State makes a showing) factors which shall
10 include—

11 “(1) whether the amount of the disallowance is
12 reasonably related to the act or omission by the
13 State which is the basis for the disallowance; and

14 “(2) whether the act or omission by the State
15 which is the basis for the disallowance was based on
16 a reasonable interpretation of Federal statutes, Fed-
17 eral regulations, or any written guidance provided by
18 the Secretary.”.

19 (2) CRITERIA FOR REDETERMINATIONS.—Sec-
20 tion 1116(d) (42 U.S.C. 1316(d)) is amended—

21 (A) by striking “(d)” and inserting
22 “(d)(1)”; and

23 (B) by adding at the end the following new
24 paragraph:

1 “(2) In conducting any reconsideration of a disallow-
2 ance of Federal financial participation by the Secretary
3 under title XIX, the Departmental Appeals Board of the
4 Department of Health and Human Services (or another
5 entity designated by the Secretary), shall, if such Board
6 or entity upholds the basis for the disallowance, determine
7 whether the amount of the disallowance properly takes
8 into account the factors listed in section 1903(x). If the
9 amount of the disallowance does not properly take into
10 account such factors, the Board shall adjust such amount
11 in accordance with such factors.”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 subsection (a) shall apply to disallowances made after the
14 date of the enactment of this Act and shall take effect
15 without regard to the promulgation of implementing regu-
16 lations.

17 **SEC. 885. TECHNICAL CORRECTIONS RELATING TO SEC-**
18 **TION 4752 OF OBRA-1990 (PHYSICIANS’ SERV-**
19 **ICES).**

20 (a) Paragraph (59) of section 1902(a) (42 U.S.C.
21 1396a(a)), as added by section 4752(c)(1)(C) of the Om-
22 nibus Budget Reconciliation Act of 1990 and as redesign-
23 nated by section 13623(a)(6) of the Omnibus Budget Rec-
24 onciliation Act of 1993, is amended by striking “sub-
25 section (v)” and inserting “subsection (x)”.

1 (b) Section 1903(i)(12) (42 U.S.C. 1396b(i)(12)), as
2 inserted by section 4752(e) of the Omnibus Budget Rec-
3 onciliation Act of 1990 and as redesignated by section
4 13631(c)(3) of the Omnibus Budget Reconciliation Act of
5 1993, is amended—

6 (1) by amending clause (i) of subparagraph (A)
7 to read as follows:

8 “(i) is certified in family practice or
9 pediatrics by the medical specialty board
10 recognized by the American Board of Med-
11 ical Specialties for family practice or pedi-
12 atrics or is certified in general practice or
13 pediatrics by the medical specialty board
14 recognized by the American Osteopathic
15 Association,”;

16 (2) by amending clause (i) of subparagraph (B)
17 to read as follows:

18 “(i) is certified in family practice or
19 obstetrics by the medical specialty board
20 recognized by the American Board of Med-
21 ical Specialties for family practice or ob-
22 stetrics or is certified in general practice or
23 obstetrics by the Medical Specialty Board
24 recognized by the American Osteopathic
25 Association,”; and

1 (3) in subparagraphs (A) and (B)—

2 (A) by striking “or” at the end of clause

3 (v);

4 (B) by redesignating clause (vi) as clause

5 (vii); and

6 (C) by inserting after clause (v) the follow-

7 ing new clause:

8 “(vi) delivers such services in the

9 emergency department of a hospital par-

10 ticipating in the State plan approved under

11 this title, or”.

12 **TITLE IX—DEPARTMENT OF**
13 **VETERANS AFFAIRS**

14 **SEC. 901. SHORT TITLE.**

15 This title may be cited as the “Veterans Health Care

16 Administrative Flexibility Act of 1994”.

17 **SEC. 902. PURPOSE.**

18 The purpose of this title is to facilitate the provision

19 of health care services by the Department of Veterans Af-

20 fairs by—

21 (1) granting the Department sufficient flexibil-

22 ity to respond rapidly and effectively to local mar-

23 keting and regulatory conditions (including health

24 care reform legislation that might be enacted by the

25 States); and

1 (2) granting the Department the authority and
2 resources to facilitate the timely acquisition of nec-
3 essary facilities and services at a local level.

4 **SEC. 903. HEALTH CARE REFORM BY THE STATES.**

5 (a) INTENT OF CONGRESS.—It is the intent of Con-
6 gress that the Department of Veterans Affairs health care
7 facilities shall participate as health care providers recog-
8 nized under health care reform legislation enacted by the
9 several States. To the extent practicable, the Secretary of
10 Veterans Affairs shall provide health care services in a
11 State enacting such reform legislation as if such facilities
12 were providers under such legislation of that State.

13 (b) PROHIBITION.—Notwithstanding any other provi-
14 sion of law, a State that enacts health care reform legisla-
15 tion may not prohibit the participation of the Department
16 as a health care provider under such legislation unless the
17 chief executive officer of the State certifies to the Sec-
18 retary that—

19 (1) the benefits to be provided by the Depart-
20 ment do not meet the requirements for quality of
21 benefits established by the reform legislation; or

22 (2) the location of Department facilities (includ-
23 ing facilities providing services by contract or agree-
24 ment with the Secretary) in the State is such that
25 the proximity of eligible persons to such facilities

1 does not meet the requirements so established for
2 such proximity.

3 **SEC. 904. AUTHORITY TO EXEMPT DEPARTMENT OF VETER-**
4 **ANS AFFAIRS HEALTH CARE FACILITIES**
5 **FROM CERTAIN PROVISIONS OF LAW.**

6 (a) IN GENERAL.—Chapter 73 of title 38, United
7 States Code, is amended—

8 (1) by redesignating subchapter IV as sub-
9 chapter V; and

10 (2) by inserting after subchapter III the follow-
11 ing new subchapter IV:

12 “SUBCHAPTER IV—EXEMPTIONS

13 “§ 7341. **Designation of exempt facilities**

14 “In order to facilitate the provision of health care
15 services by the Department in a manner that is responsive
16 to local market and regulatory conditions, the Secretary
17 may designate health care facilities of the Department
18 which shall be exempt from provisions of law as specified
19 in this subchapter.

20 “§ 7342. **Contracts and agreements**

21 “(a) If designated by the Secretary under section
22 7341 of this title to be exempt from provisions of law as
23 specified in this subchapter, a health care facility of the
24 Department may enter into contracts and agreements for
25 the provision of health care services and contracts and

1 agreements for other services (including procurement of
2 equipment, maintenance and repair services, and other
3 services related to the provision of health care services)
4 as specified in this section.

5 “(b) Contracts and agreements (including leases)
6 under subsection (a) shall not be subject to the following
7 provisions of law:

8 “(1) Section 8110(c) of this title, relating to
9 contracting of services at Department health care fa-
10 cilities.

11 “(2) Section 8122(a)(1) of this title, relating to
12 the lease of Department property.

13 “(3) Section 8125 of this title, relating to local
14 contracts for the procurement of health care items.

15 “(4) Section 702 of title 5, relating to the right
16 of review of agency wrongs by the courts of the
17 United States.

18 “(5) Sections 1346(a)(2) and 1491 of title 28,
19 relating to the jurisdiction of the district courts of
20 the United States and the United States Court of
21 Federal Claims, respectively, for the actions enumer-
22 ated in such sections.

23 “(6) Subchapter V of chapter 35 of title 31, re-
24 lating to the adjudication of protests of violations of
25 procurement statutes and regulations.

1 “(7) Sections 3526 and 3702 of such title, re-
2 lating to the settlement of accounts and claims, re-
3 spectively, of the United States.

4 “(8) Subsection (b)(7), (e), (f), (g), and (h) of
5 section 8 of the Small Business Act (15 U.S.C.
6 637(b)(7), (e), (f), (g), and (h)), relating to require-
7 ments with respect to small businesses for contracts
8 for property and services.

9 “(9) The provisions of law assembled for pur-
10 poses of codification of the United States Code as
11 section 471 through 544 of title 40 that relate to the
12 authority of the Administrator of General Services
13 over the lease and disposal of Federal Government
14 property.

15 “(10) The provisions of the Office of Federal
16 Procurement Policy Act (41 U.S.C. 401 et seq.), re-
17 lating to the procurement of property and services
18 by the Federal Government.

19 “(11) Chapter 3 of the Federal Property and
20 Administrative Services Act of 1949 (41 U.S.C. 251
21 et seq.), relating to the procurement of property and
22 services by the Federal Government.

23 “(12) Office of Management and Budget Cir-
24 cular A-76.

1 “(c)(1) Notwithstanding any other provision of law,
2 contracts and agreements for the provision of health care
3 services under this section may include contracts and
4 agreements with insurers, health care providers, or other
5 individuals or entities that provide health care services.

6 “(2) Contracts and agreements under this subsection
7 may be entered into without prior review by the Central
8 Office of the Department.

9 “(d)(1) A contract or agreement under this section
10 for services other than the services referred to in sub-
11 section (c) (including a contract or agreement for procure-
12 ment of equipment, maintenance and repair services, and
13 other services related to the provision of health care serv-
14 ices) shall not be subject to prior review by the Central
15 Office of the Department if the amount of the contract
16 or agreement is less than \$250,000.

17 “(2) The Central Office may conduct a prior review
18 of a contract or agreement referred to in paragraph (1)
19 if the amount of the contract or agreement is \$250,000
20 or greater.

21 **“§ 7343. Department personnel**

22 “Notwithstanding any other provision of law, with re-
23 spect to facilities designated by the Secretary under sec-
24 tion 7341 of this title to be exempt from provisions of law
25 as specified in this subchapter, the Secretary may—

1 “(1) appoint health care personnel to positions
2 in that facility in accordance with such qualifications
3 for such positions as the Secretary may establish;
4 and

5 “(2) promote and advance personnel serving in
6 such positions in accordance with such qualifications
7 as the Secretary may establish.

8 **“§ 7344. Funding**

9 “(a) To the extent authorized by current law, the Sec-
10 retary may continue to collect funds from third party pay-
11 ers to defray the costs of providing health care services
12 to veterans.

13 “(b) As a repository for funds referred to in sub-
14 section (a), there is established in the Treasury a fund
15 to be known as the Department of Veterans Affairs Health
16 Care Reform Fund (hereafter referred to in this section
17 as the ‘Fund’).

18 “(c)(1) Notwithstanding any other provision of law,
19 amounts shall be deposited in the Fund as follows:

20 “(A) Amounts collected as referred to in sub-
21 section (a).

22 “(B) Amounts made available based on a deter-
23 mination under subsection (d).

24 “(C) Amounts transferred to the Fund under
25 subsection (e).

1 “(D) Such other amounts as the Secretary de-
2 termines to be necessary.

3 “(E) Such other amounts as may be appro-
4 priated to the Fund.

5 “(2) The Secretary shall make available amounts
6 under subparagraphs (B) and (D) of paragraph (1) from
7 amounts appropriated to the Department of Veterans Af-
8 fairs for the provision of health care services.

9 “(3) The Secretary shall establish and maintain a
10 separate account under the Fund for each health care fa-
11 cility designated under section 7341 of this title as exempt
12 from the provisions of law as specified in this subchapter.
13 Any deposits and expenditures with respect to a des-
14 ignated facility shall be made to or from the account es-
15 tablished and maintained with respect to that facility.

16 “(d)(1) For each year of the operation of a des-
17 ignated facility, the Secretary shall deposit in the account
18 of the Fund for the facility an amount (as determined by
19 the Secretary) equal to the amount that would otherwise
20 be made available to the facility for the payment of the
21 cost of health care services by the facility in that year.
22 The Secretary shall deposit such amount at the beginning
23 of such year.

1 “(2) The costs referred to in paragraph (1) shall not
2 include costs relating to the provision by the Secretary of
3 the following services:

4 “(A) Services relating to post-traumatic stress
5 disorder.

6 “(B) Services relating to spinal-cord injuries.

7 “(C) Services relating to substance abuse.

8 “(D) Services relating to the rehabilitation of
9 blind veterans.

10 “(e) Funds deposited in the Medical-Care Cost Re-
11 covery Fund established under section 1729(g) of this title
12 during any fiscal year in an amount in excess of the Con-
13 gressional Budget Office baseline (as of the date of the
14 enactment of the Veterans Health Care Administrative
15 Flexibility Act of 1994) for deposits in that fund for that
16 fiscal year shall not be subject to paragraph (4) of section
17 1710(f), 1712(f), or 1729(g) of this title, as the case may
18 be, but shall be transferred to the Fund. Such transfer
19 for any fiscal year shall be made at any time that the total
20 of amounts so received less amounts estimated to cover
21 the expenses, payments, and costs described in paragraph
22 (3) of section 1729(g) of this title is in excess of the appli-
23 cable Congressional Budget Office baseline.

24 “(f) Notwithstanding any other provision of law, the
25 facility director for each facility designated under section

1 7341 of this title as exempt from the provisions of law
2 as specified in this subchapter shall determine the costs
3 for which amounts in the Fund may be expended in pro-
4 viding health care services at that facility.

5 **“§ 7345. Expenditure authority**

6 “(a)(1) Except as provided in paragraph (2), if des-
7 ignated by the Secretary under section 7341 of this title
8 to be exempt from provisions of law as specified in this
9 subchapter, a health care facility of the Department may
10 expend funds under this section in order to cover the fol-
11 lowing costs:

12 “(A) Costs of marketing and advertising health
13 care services.

14 “(B) Costs of legal services provided to the fa-
15 cility by the General Counsel of the Department re-
16 lating to this subchapter.

17 “(C) Costs relating to acquisition (including ac-
18 quisition of land), construction, repair, or renovation
19 of facilities.

20 “(2) Costs under this section shall not include costs
21 relating to a major medical facility project or a major
22 medical facility lease as such terms are defined in sub-
23 paragraphs (A) and (B) of section 8104(a)(3) of this title,
24 respectively.”.

1 (b) CLERICAL AMENDMENT.—The table of sections
 2 at the beginning of chapter 73 is amended by striking out
 3 the item relating to the heading for subchapter IV and
 4 inserting in lieu thereof the following:

“SUBCHAPTER IV—EXEMPTIONS

“7341. Designation of exempt facilities.

“7342. Contracts and agreements.

“7343. Department personnel.

“7344. Funding.

“7345. Expenditure authority.

“SUBCHAPTER V—RESEARCH CORPORATIONS”.

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